DEPT.- 65

JOB- 21

REEL- 48

CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

VP 23007

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health, BUREAU OF Vital Statistics CREATED DURING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

Authorization No. 345

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily.

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals.

D. [X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs. and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD: (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval Robert E. Farber M.D. Title: Commissioner of Health 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A. To be sold as scrap or waste paper	B. To be Burned or shredded	C. Historical, (to be transferred to Dept. of Legislative Reference.)
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ]	[X]	[ ]

REMARKS: 2 negative Rolls

C P Force Records Management Officer 3/28/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR

2. APPROVED: CITY SOLICITOR

3. APPROVED: CITY COMPTROLLER

4. APPROVED: CITY TREASURER

5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS

6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM

7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

Spec- 12-23-21- E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caleb Clarke Magruder

(a) Residence No. Johns Hopkins Hospital St., 7 Ward Upper Marlboro, Prince George Co, Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? 84 yrs. 4 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Bettie Rice Magruder

6-DATE OF BIRTH (month, day and year) Jany-9-1839.

7-AGE. 84 yrs. 4 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Clerk of the

(b) General nature of industry, business, or establishment in which employed (or employer): Court of Appeals

(c) Name of employer: of Maryland.

9-BIRTHPLACE (city or town) (State or Country). Upper Marlboro Maryland

PARENTS.

10-NAME OF FATHER. Caleb Clarke Magruder

11-BIRTHPLACE OF FATHER (city or town) ? ? (State or Country). Prince George Co.

12-MAIDEN NAME OF MOTHER. Mary Sprigg Belt

13-BIRTHPLACE OF MOTHER (city or town) ? ? (State or Country) Prince George Co. Md.

14- (Informant) Mr. C. C. Magruder, (son)

(Address) Upper Marlboro, Md.

15-

Filed ..... 192..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year).

17- I HEREBY CERTIFY, That I attended deceased from ....., 19..... to....., 19.....

that I last saw h.....alive on....., 19.....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds

CONTRIBUTORY .....
(Secondary)

.....(Duration).....yrs.....mos.....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed)..... M. D.

....., 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Bell's, Prince George Co. Md. DATE OF BURIAL. June-6-23

20-UNDERTAKER. STEUART & MOWEN COMPANY (Michael F. Woodall, Successor) ADDRESS 108 W. NORTH AVE.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS! Exact statement of OCCU... in plain terms, so that it may be properly classified. Exa... instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76111

CERTIFICATE OF DEATH.

15 100-00 D76111

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Morrow

(a) Residence No. 2505 Elsinor Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) July 24 1855

7-AGE. 69 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Painter

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Delaware

PARENTS.

10-NAME OF FATHER. George Morrow

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Delaware

12-MAIDEN NAME OF MOTHER. Elizabeth Reed

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md.

14- (Informant) Municipal Hospital Records

(Address).....

15- Filed MAY 26 1923 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 26, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 19 1923 to May 26 1923 that I last saw h... alive on May 25 1923, and that death occurred, on the date stated above, at 2:10 A.M. The CAUSE OF DEATH* was as follows:

Arteriosclerosis, General + Cerebral

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McPowell, M. D.

5-26, 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal or Homicidal.** (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park Cem	May 28 1923
UNDERTAKER.	ADDRESS
John O. Mitchell	1201 W Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D76112

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-003 D76112

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital. ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel Cornish. (C).

(a) RESIDENCE NO. 118 Seldner Place. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 11 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5, 1917.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	11	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles H. Cornish.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Viola Johnson. (C).

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Md.

14 Informant Viola Cornish. (C) (mother).
(Address) 118 Seldner Place.

15 MAY 26 1923 Robert F. Harrison, 192
Burial Permit Clerk. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Internal injuries
accidentally struck and run over
by Auto-truck.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner)

May 24, 1923. (Address) 1017 E. Charles St.

(C) *State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] DATE OF BURIAL 5/26/1923

20 UNDERTAKER [illegible] ADDRESS 578

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D76113

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D76113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Anna Meyers

(a) Residence No. Bay View Asylum. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Meyer.

6-DATE OF BIRTH (month, day and year): 1843 - JUNE 27

7-AGE: 79 yrs. 10 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Germany

PARENTS:

10-NAME OF FATHER: Unknown?

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown ?

12-MAIDEN NAME OF MOTHER: Unknown?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown ?

14- Municipal Hospital Record
(Informant)

(Address)

15- Filed May 26 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 22, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 19 1923 to May 22 1923, that I last saw her alive on May 21 1923, and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Broncho-Pneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McPowell M. D

5-22-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery — DATE OF BURIAL: May 26 1923

20-UNDERTAKER: George L. Schmidt & Son — ADDRESS: 1101 Fulton Ave.

MAY 26 1923

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76114

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76114

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 444 N. Lakewood Ave 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hoffman.

(a) RESIDENCE NO. 444 N. Lakewood Ave 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late annie Hoffman

6 DATE OF BIRTH (month, day, and year): July 1st 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Baker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Anna E. Hoffman (Address) 444 N. Lakewood Ave

15 Filed MAY 26 1923 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May. 24th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 23rd, 1923, to May 24th, 1923, that I last saw him alive on May 23rd, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Larynx

(duration) — yrs. 5 mos — ds.

CONTRIBUTORY (Secondary) Influenza

(duration) — yrs. 2 mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Edgar Poe Hutton, M. D.

May 24, 1923 (Address) 1127 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	May 28 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeller	4008 Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76115

CERTIFICATE OF DEATH.

90 D76115

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME M. Martha Shaare

(a) RESIDENCE. No. Mt Hope Retreat ST. 28th WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single -

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	54	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious -

(b) General nature of industry, business, or establishment in which employed (or employer) R - work -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Adam Shaare

11 BIRTHPLACE OF FATHER (city or town) (State or country) (?) Germany

12 MAIDEN NAME OF MOTHER Mary Cinatlat

13 BIRTHPLACE OF MOTHER (city or town) (State or country) (?) France

14 Informant (Address) Records of Mt Hope Retreat Mt Hope Balto Md -

15 Filed 19 Robert P. Harrison, Registrar

26 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 30, 1914, to May 26, 1923.

that I last saw h[illegible] alive on May 25, 1923.

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis -

abt (duration) 0 yrs. 0 mos. 10 ds.

CONTRIBUTORY (Secondary) Chr Val Dis of Heart & Depressed Psychosis. (duration) abt 12 years yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Agnes Convent	May 28 1923
20 UNDERTAKER	ADDRESS
Henry Jenkins Sons	Orchard & Collok

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76116

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76116

CERTIFICATE OF DEATH.

21

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Chambers.

(a) RESIDENCE NO. Bay View Hospital ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem

4 COLOR OR RACE Bl.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unkn.

6 DATE OF BIRTH (month, day, and year)

7 AGE 39 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va. (State or country)

PARENTS

10 NAME OF FATHER Unkn.

11 BIRTHPLACE OF FATHER (city or town) " (State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant (Address)

15 Filed . 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

MAY 26 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1923

17 I HEREBY CERTIFY, That I attended deceased from May 6 . 1922 . to May 22 . 1923. that I last saw h[illegible] alive on May 22 . 1923 and that death occurred, on the date stated above, at 12.15 p m

The CAUSE OF DEATH* was as follows:

Facial Erysipelas

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Terminal Broncho Pneumon (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Bay View Hospital

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical - Lab.

(Signed) H. E. Edmunds, M. D.

. 19 (Address) Boyd and Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAY 26 1923

UNIVERSITY OF MARYLAND.

Commissioner Health.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT IS PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 1-10-21-M 1500 Bks.

Perlature

169099 *

D576117

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D576117

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 24 WARD)

2-FULL NAME Reada Burke.

(a) RESIDENCE No. 645 Harvey St. City ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos., ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND~~ of ~~OR WIFE~~ of: Josephine Burke (mother),

6 DATE OF BIRTH (month, day, and year): July 4, 1923.

7 AGE: Years —; Months 10.; Days 21.; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Clarence Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Josephine Olonski,

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: JOHNS HOPKINS HOSPITAL (Address) Baltimore.

15 Filed . 19 Robert P. Harrison. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25, 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1923. to May 25, 1923. that I last saw HE alive on May 25, 1923. and that death occurred, on the date stated above, at 1.40 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus.

(duration) yrs. 4 mos 14 ds.

CONTRIBUTORY (Secondary): Otitis media

(duration) yrs 2 mos. 14 (+) ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of —

Was there an autopsy? Yes. What test confirmed diagnosis? Postmortem examination of organs.

(Signed) William H. F. Wartham, M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross C. & C.

DATE OF BURIAL: 5-28 1923

20 UNDERTAKER: E & B Hale

ADDRESS: 1152 E. Pratt St.

M. B.—WHITE PENCIL, WITH CARBON, FOR ... mation should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ba...

5-26 1923

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Marasmus of 4 1/2 months duration following pertussis, pneumonia and postauricular abscess.

Spec—12-23-21—E.B.R.S.—400 Blks.

D 76118

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 76118

CERTIFICATE OF DEATH.

3

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 108 N Eden al St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Walter J. Haney

(a) Residence No. 108 Mt. Eden al St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX M.

4-COLOR OR RACE, W.

5-Single, ~~Married~~, ~~Widowed~~, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1/18/1875

7-AGE. 48 yrs. 4 mos. 7 ds. If LESS than 1 day ....hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Painter

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto
(State or Country)..... Md

PARENTS.

10-NAME OF FATHER. James Haney

11-BIRTHPLACE OF FATHER (city or town)..... Balto
(State or Country)..... Md

12-MAIDEN NAME OF MOTHER. Mary E. Baker

13-BIRTHPLACE OF MOTHER (city or town)..... Balto
(State or Country)..... Md

11-Informant..... Jennie L. Zeltz

(Address)..... 2131 Chelsea Ter.

12-Filed MAY 26 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 25, 1923

17- I HEREBY CERTIFY, That I attended deceased from May. 20 1923 to May 25, 1923.

that I last saw him alive on May. 24. 1923

and that death occurred, on the date stated above, at 5.25 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) —

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? no.

(Signed) Thos Jordan M. D.

, 19 (Address) 888 N Eden al

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Western Cemetery	May 28, 1923
20-UNDERTAKER.	**ADDRESS**
George J. Smith	Holland St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76119

CERTIFICATE OF DEATH.

74-001 D76119

1-PLACE OF DEATH

City of BALTIMORE: (No. 629 N Conway St., 22 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Cecilia Jeffer

(a) Residence No. 629 W Conway St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F.

4-COLOR OR RACE, W

~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced~~ (Write the word.) Widow

5a-If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of H. T. Jeffer

6-DATE OF BIRTH (month, day and year) 11-5-54

7-AGE. 68 yrs. 6 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS

10-NAME OF FATHER, Mower Litz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) J. T. Jeffer

(Address) 629 W Conway ave

MAY 26 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-25-23

17- I HEREBY CERTIFY, That I attended deceased from 5-24- 1923 to 5-25 1923

that I last saw h[illegible] alive on 5-25 1923

and that death occurred, on the date stated above, at 4a. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia.

Generalized Arteriosclerosis

Hypertension.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia 2 mos.

(Duration) 1 yrs. mos. 0 days.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Schuman M. D.

5-26 1923 (Address) 604 Linden

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 5/28/23 19
Loudon Park Cem.	
20-UNDERTAKER.	ADDRESS
Fred A. Krause & Son	703 Hanover St

SHOULD BE EXACTLY: PHYSICIANS should be CHOSE OF [illegible] should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Apoplexia.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76120

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76120

160.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3313 Toone St., 26 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Dolores Riser

(a) Residence No. 3313 Toone St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of -

6-DATE OF BIRTH (month, day and year) May 17

7-AGE. ....yrs. ....mos. 9 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto, Md.

PARENTS.

10-NAME OF FATHER, Roland G. Riser

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Mary Schmidt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md

14-

(Informant) Roland G. Riser

(Address) 3313 Toone St.

15-

Filed MAY 26 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 26. 1923

17- I HEREBY CERTIFY, That I attended deceased from May 17, 1923 to May 26 1923

that I last saw h[illegible] alive on May 24 1923

and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Asthenia

(Duration) ....yrs. ....mos. ....ds

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Fitlow M. D.

5/26, 1923 (Address) 315 S. Highland Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Carmel Cem. DATE OF BURIAL, May 27 1923

20-UNDERTAKER, Zirkler & Zirkler ADDRESS 1739 E. Eager St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76121

D76121

10

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alden Clark.

(a) RESIDENCE NO. 612 S. ann ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 29-1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	0	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) md.

PARENTS

10 NAME OF FATHER Wm. Clark

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) md

12 MAIDEN NAME OF MOTHER Christina Kahler

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) md

14 Informant Christina Clark
(Address) 612 S. ann St.

15 MAY 26 1923, 19 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1923

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1923, to May 25, 1923, that I last saw h[illegible] alive on May 25, 1923, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria, nasal, tonsillar & pharyngeal.
(duration) — yrs. — mos. 7+ ds.

CONTRIBUTORY (Secondary) Myocarditis
(duration) — yrs. — mos. 4+ ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Culture (+)

(Signed) B. Hallaran, M. D.

5/26/23 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL May 26 1923

20 UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 E. Coga St.

MAY 26 1923

GE should be stated EXACTLY. PHYSICIA[illegible] should be stated
at it may be properly classified. Exact state[illegible]nt of OCCUPA-
s on back of certificates.

mation should be carefully supplied. AGE s
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks. 76422

D76122

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 127 D76122

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter C. Mc Daniel

(a) RESIDENCE NO. Live Oak, Fla. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Caroline Webb Mc Daniel

6 DATE OF BIRTH (month, day, and year) Aug 10, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fla.

PARENTS

10 NAME OF FATHER Thomas J. Mc Daniel

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Martha Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ala.

14 Informant Mrs. Caroline W. Mc Daniel (Address) Live Oak Fla.

15 MAY 27 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 18, 1923, to May 26, 1923,

that I last saw him alive on May 26, 1923,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Multiple abscesses.

over

(duration) yrs. 14 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fla.

Did an operation precede death? Yes Date of 4/26/23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C.B. Price, M. D.

, 19 (Address) Union Memorial Hospital Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Madison Fla.

DATE OF BURIAL May 27 1923

20 UNDERTAKER John. B. Mitchell

ADDRESS 1201 W. Fayette

N. B.—WHITE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Abdominal

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76123

CERTIFICATE OF DEATH.

49 D76123

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 382 Forest ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Palmisano

(a) RESIDENCE No. 382 Forest ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 20. 1920

7 AGE 2 Years 7 Months 6 Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Antonino Palmisano

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Josephina Corsaro

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Antonino Palmisano
(Address) 382 Forest st

15 Filed MAY 27 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 20, 1923, to May 1, 1923,

that I last saw her alive on May 20, 1923,

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Rt Eye

(duration) yrs. 4 mos. 6 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Ira L. Kilpatrick M. D.

May 26. 1923 (Address) 1038 W Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincent Cemetery

DATE OF BURIAL May 27, 1923

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford ave

N.B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76124 ✓ D76124

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3 ST., 3 WARD)

2-FULL NAME Max Weinstein

(a) RESIDENCE NO. 1431 Gough ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Yetta Weinstein

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE: Years 46 | Months — | Days — | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harry Weinstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Yetta Weinstein 1431 Gough Street

15 MAY 27 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1923, to May 26, 1923, that I last saw him alive on May 26, 1923 and that death occurred, on the date stated above, at 8.15 A. m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) yrs. mos few min. ds.

CONTRIBUTORY (Secondary) Chr. bronchitis (asthmatic); Cardiac hypertrophy

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Isidore J. Fry M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel — DATE OF BURIAL: May 27 1923

20 UNDERTAKER: Josh Lewis — ADDRESS: 1437 Eutaw

N. B.—WRITE PLAINLY, WITH INDELIBLE PENCIL. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Corrected Copy Town 1118-001

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 76125

CERTIFICATE OF DEATH.

Emil Holman

D 76125

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST., WARD

2-FULL NAME Harry Rosen

(a) RESIDENCE NO. 5 Logan ST., West Va WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Unknown mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Helen

6 DATE OF BIRTH (month, day, and year): Oct 6 1892

7 AGE: Years 30 Months 7 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Solomon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rachel Gordin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Johns Hopkins Hospital

15 Filed May 27 19 23 C. PARKSON JONES M COMMISSIONER OF HEALTH Robert Knabe

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25 19 23

17 I HEREBY CERTIFY, That I attended deceased from May 25, 19 23, to May 25, 19 23, that I last saw him alive on May 25, 19 23, and that death occurred, on the date stated above, at 6:30 m.

The CAUSE OF DEATH* was as follows:

Femoral hernia

(duration) About 7 yrs. mos ds.

CONTRIBUTORY (Secondary) ? Embolism, Postoperative hemorrhage (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of May 24 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Emil Holman, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Washington Road — DATE OF BURIAL: May 27 19 23

UNDERTAKER: John Levis — ADDRESS: 1409 E Baltimore St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76126

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D76126

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes' Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benedict Deckers

(a) RESIDENCE NO. 1743 E. 25th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day 5 hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry B. Decker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Helen M. Cubbins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant (Address) Henry B. Decker, 1743 E. 25th, St.

15 MAY 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1923

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1923, to May 26, 1923, that I last saw h[illegible] alive on May 26, 1923, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity (7 mos.)

(duration) yrs. mos 5 hrs

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Marcia Faulkner M. D.

, 19 (Address) St. Agnes' Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: May 28 1923

20 UNDERTAKER: Elmer St. Conklin — ADDRESS: 924 E. Eager St.

N. B.—WRITE PLAINLY with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76127

CERTIFICATE OF DEATH.

31

D76127

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1232 W Ostend St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph F Schoen

(a) Residence No. 1232 W Ostend St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept 26, 1880

7-AGE, 42 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Machinist

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Crown Cork & Seal Co.

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Frederick Schoen

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Katherine Graublen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Emily Elsewin

(Address) 1232 W Ostend St

15- Filed MAY 27 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 25 1923

17- I HEREBY CERTIFY, That I attended deceased from April 18 1923 to May 25 1923

that I last saw he alive on May 24 1923

and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) F H Holtz, M. D.

May 26 23 (Address) 1703 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Emmanuel Cem. DATE OF BURIAL, May 28. 1923

20-UNDERTAKER, R Heemann ADDRESS 320 Broadway

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

D76128 — 129 — D76128

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No.) 810 S. Kenwood Ave. (St.) 1 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Charles Kommalan

(a) RESIDENCE. No. 810 S. Kenwood Ave St. Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 8 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Kommalan

6 DATE OF BIRTH (month, day, and year) Sept. 11-1856.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stove assembler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sheppard Stove Co

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Carl Kommalan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelm Robach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna Kommalan
(Address) 810 S. Kenwood Ave

15 Filed MAY 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1923

17 I HEREBY CERTIFY, That I attended deceased from May 22nd, 1923, to May 26th, 1923, that I last saw h[illegible] alive on May 26th, 1923, and that death occurred, on the date stated above, at 11.45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute nephritis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Labora[illegible]

(Signed) Philibert Artigiani M. D.

, 19 (Address) 1942 E. Fayette St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	May 29 1923
20 UNDERTAKER	ADDRESS
Zirkler + Zirkler	1739 Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76129

CERTIFICATE OF DEATH. 101-001 D76129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Pendleton

(a) RESIDENCE. No. 1418 McCollough ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant [illegible] Stewart, Warden
(Address)

15 Filed MAY 27 1923 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May - 25 - 1923

17 I HEREBY CERTIFY, That I attended deceased from May - 20, 1923, to May - 25, 1923, that I last saw him alive on May - 24, 1923, and that death occurred, on the date stated above, at 8.25 a m.

The CAUSE OF DEATH* was as follows:

Cardiac failure - Toxemia and Exhaustion

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) William H. Schwark, M. D.

5/25, 1923 (Address) Maryland Penitentiary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	5-28-23
20 UNDERTAKER	ADDRESS 916
Daniel Eagan	Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76130

CERTIFICATE OF DEATH.

101-001

D76130

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital. ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gordon Ernest Rouzer.

(a) RESIDENCE No. 243 N. Payson St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6, 1922.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Milton Rouzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Ruth Rouzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) 243 N. Payson Street

Filed MAY 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1923, to May 27, 1923, that I last saw him alive on May 27, 1923, and that death occurred, on the date stated above, at 4.05 A. m.

The CAUSE OF DEATH* was as follows:

General Peritonitis,

probably pneumococcal.

(duration) 0 yrs. 0 mos 3 ds.

CONTRIBUTORY (Secondary) post

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) P. B. Price, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 28, 23
20 UNDERTAKER	ADDRESS
H. S. Neufeld	2156 Fred'k Ave

MAY 27 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

NAME should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pneumococcus Infection

Spec.—1-10-21—M&T—1500 Blks.

D76131 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D76131

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH :

CITY OF BALTIMORE: (No.) 421 N. 24th St. (ST.) (WARD) 17

2-FULL NAME Catherine Parks

(a) RESIDENCE NO. 421 N. 24th St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles S. Parks

6 DATE OF BIRTH (month, day, and year) Aug. 30-1889

7 AGE Years 33 Months 8 Days 25 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Maryland

PARENTS

10 NAME OF FATHER Columbus Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Maryland

12 MAIDEN NAME OF MOTHER Amanda Gaines

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Maryland

14 Informant Charles S. Parks (Address) 421 N. 24th St

15 MAY 27 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1923

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1923, to May 25, 1923, that I last saw h[illegible] alive on May 25, 1923, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. 1 mos. days

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. days

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

May 28 1923 (Address) 1120 N. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr. Mayo (Hampden) DATE OF BURIAL May 28 1923

20 UNDERTAKER Horace H. Burgee ADDRESS 363 Falls Rd.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76132

CERTIFICATE OF DEATH.

7 D76132

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3124 Monument ST., 7 WARD)

2-FULL NAME Melvin G. Baker

(a) RESIDENCE NO. 3124 Monument ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, preferably with typewriter. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Wm. G. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Viola Bartlett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant Wm. G. Baker; (Address) 3124 E Monument St

15 MAY 27 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1923

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1923, to May 26, 1923, that I last saw h[im] alive on May 26, 1923, and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

Complicating measles

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J Schmidt, M. D.

5/26, 1923 (Address) 701 N Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: May 27 1923

20 UNDERTAKER: Leo G. Leverk — ADDRESS: North & Harford Ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76133 D76133

CERTIFICATE OF DEATH.

7H-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 635 W. Barre St. ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Caita.

(a) RESIDENCE NO. 635 W. Barre St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Rose Caita.

6 DATE OF BIRTH (month, day, and year) June 30th. 1881.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	10	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Jeweler.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy.

PARENTS

10 NAME OF FATHER Joseph Caita.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Mary Arena.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant Rose Caita. (wife) (Address) 635 W. Barre St.

15 MAY 27 1923 ROBERT P. KRANTZ Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25th. 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Chotlexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto Reinhardt, M. D. (Coroner.)

May 26th, 192 3 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery DATE OF BURIAL 5/28 1923

20 UNDERTAKER Geo. J. Ruth ADDRESS 1338 Hope Lane

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Lennartz

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76134

D76134

X 118-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hospital (St.) (WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Lennartz

(a) RESIDENCE No. Perry Hall. Balto Co. St. Md (WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Lennartz

6 DATE OF BIRTH (month, day, and year): May 11 - 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Conrad Drayer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Holland

12 MAIDEN NAME OF MOTHER: Angelia Huegelmyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary Facey

(Address): 449 Hollins St

15 MAY 27 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25 - 1923

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1923 to May 25 - 1923. that I last saw h alive on May 25 - 1923, and that death occurred, on the date stated above, at 3 40 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) 2 — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Intestinal Obst.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of May 25/23

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S W Kinney M. D.

, 19 (Address) 8

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Cathedral Cem	5/28/1923
20 UNDERTAKER J. G. Moran	ADDRESS 300 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76135

D76135

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2230 Eagle St. (St.) 70 (Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Emma Elizabeth Disney.

(a) RESIDENCE. NO. 2230 Eagle (St.) (Ward.)

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Nelson Disney.

6 DATE OF BIRTH (month, day, and year) Jan 31, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles F. Benner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Martha M. Tiepermann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Charles F. Benner.

(Address) 2230 Eagle St

15 MAY 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1923

17

I HEREBY CERTIFY, That I attended deceased from May 23, 1923, to May 25, 1923,

that I last saw h[illegible] alive on May 25, 1923,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Nephritis - Arteriosclerosis

(duration) History indefinite

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Wm Michel, M. D.

May 26 1923 (Address) 2401 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	5/28 - 1923
20 UNDERTAKER	ADDRESS 517 N.
W. C. Banning & Son	Schroeder St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

76137

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76136

CERTIFICATE OF DEATH.

23129

D76136

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Henderson

(a) Residence No. 1015 Sharp St. St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1893

7-AGE. 30 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Minister

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Norway

PARENTS.

10-NAME OF FATHER. Martin Henderson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Norway

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Norway

14-

(Informant) Municipal Hospital Records

(Address)

15-FILED MAY 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 24, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 16 19 23 to May 24 19 23

that I last saw h. in alive on May 24 19 23.

and that death occurred, on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:

Acute exacerbation of chronic nephritis - uraemia

(Duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Tuberculosis pulmonalis

(Duration) ..... yrs. 2 mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

5-25-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Brooklyn N.J.	5/28 1923
20-UNDERTAKER.	ADDRESS
Jones & Toulson	120 W. Lanvale St.

SHOULD BE CAREFULLY SUPPLIED. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. EXACT statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

76136 (See Letter + affadirit attached)

163649 " D76137

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

13 ✓ D76137

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. " " " ST., 6 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Goodman.

(a) RESIDENCE NO. 133 Patterson Park Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of [or) WIFE of: Lena Goodman (wife)

6 DATE OF BIRTH (month, day, and year): Dec 15 1870

7 AGE — Years: 52 — Months: 5 — Days: 12 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Aaron Goodman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Sarah Meiner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: JOHNS HOPKINS HOSPITAL Records

(Address)

15 MAY 28 1923 ROBERT A. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 27 1923

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1923, to May 27, 1923, that I last saw him alive on May 22, 1923, and that death occurred, on the date stated above, at 5:2 a. m.

The CAUSE OF DEATH* was as follows:

Kidney Tumor - path.
report not known

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Prob. Pulmonary Embolism? (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of May 17

Was there an autopsy? No

What test confirmed diagnosis? Path Tumor - Symptoms Clinical Path.

(Signed) E. E. Reichert, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hollywood K. Va.

DATE OF BURIAL: May 27 19 23

20 UNDERTAKER: Fant Sons, 1739 E. Balto

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 1 - 1923

This is to certify that the age given on Baltimore City Death Certificate # 7637 is incorrect the same should read as follows. Date of Birth month day December ~~15th~~ 4th 1870. Age should be 52yr. 5-12

Sworn to before me this 1st day of June 1923.

a Notary Public for the City of Baltimore State of Maryland

by: Robert Goodman. Son of the deceased.

Robt J. Goodman Seal
Son

George H. Gregg
Notary Public

THE JOHNS HOPKINS HOSPITAL

May 31, 1923

Harry W. Goodman's
date of birth is given
as December 15. 1870

F. L. Reichert, M.D.

For C. Hampson Jones
Health Commissioner

Spec.—1-10-21—M&T—1500 Bks.

Konig

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76138 ✓ D76138

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 Druid Hill ave ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia F. Konig

(a) RESIDENCE NO. 1409 Druid Hill ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): [illegible] 1831

7 AGE: Years 92 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Holi Harris

(Address) 5-11 Park ave

15 MAY 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/24/1923

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1923, to May 26, 1923, that I last saw h alive on May 26, 1923, and that death occurred, on the date stated above, at 6:45 P m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John A. Fordyce M. D.

19 (Address) 1019 Druid Hill ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: 5 28 23

20 UNDERTAKER: Frost Holland — ADDRESS: 1631 D. H. ave

MAY should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76139

CERTIFICATE OF DEATH.

124 D76139

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 S. Carrollton Ave St. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine J. Fink

(a) RESIDENCE. No. 114 S. Carrollton Ave ST. WARD.

(Usual place of abode) about 50 (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? about 50 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed or divorced (or) WIFE of Frances J. Fink

6 DATE OF BIRTH (month, day, and year) Feb 4 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67 yrs - 67	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) Keeping House

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Francis J. Fink (Address) 114 S. Carrollton Ave

15 Filed MAY 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1923

17 I HEREBY CERTIFY, That I attended deceased from May 20 1923 to May 25 1923 that I last saw her alive on May 25 1923 and that death occurred, on the date stated above, at 6-30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endo-Carditis complicating Rheumatic Fever

(duration) 3 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Interstitial Nephritis

(duration) yrs. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Examination

(Signed) Henry C. Ohle M. D.

May 25 1923 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	May 28 1923
20 UNDERTAKER	ADDRESS
P. J. Cavanaugh & Son	901 Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76140

CERTIFICATE OF DEATH.

100-001

REGISTERED No. D76140

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 Poplar St., Curtis Bay ST., 25 WARD)

2-FULL NAME William Edward Watts, Jr.

(a) RESIDENCE No. 104 Poplar St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 11 mos. 26 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) June 12th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Curtis Bay Md.

PARENTS

10 NAME OF FATHER William Edward Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Nellie May Chenowith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address) William Edward Watts, Jr. 104 Poplar St.

15 MAY 28 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1923

17 I HEREBY CERTIFY, That I attended deceased from 5/17/ 1923 to 5/26/ 1923. that I last saw him alive on May 26 1923. and that death occurred, on the date stated above, at 12:25 p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Empyaema

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? yes. Date of 5/25/23

Was there an autopsy? no.

What test confirmed diagnosis? Pus drained from pleural cavity.

(Signed) Geo. B. Wood M. D.

5/26 1923 (Address) 211 Church St. Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery. DATE OF BURIAL 5/28 1923

20 UNDERTAKER Henry W. Mears & Son ADDRESS 805 Fulton St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76141

CERTIFICATE OF DEATH.

7H-001 D76141

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 519 Richwood Ave. Govans ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Harrison

(a) RESIDENCE NO. 519 Richwood Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Johnson

6 DATE OF BIRTH (month, day, and year) Mar. 9, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs or ..min.
	74	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired -Hardware

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Nicholas Harrison

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER ------ Greenfield

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs. Leo J. Downey

(Address) 519 Richwood Avenue

15 MAY 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1914 to May 26 1923.

that I last saw him alive on May 24 1923.

and that death occurred, on the date stated above, at 11.50 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 9 yrs. mos ds.

CONTRIBUTORY (Secondary) Hemiplegia (Right)

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Hearn M. D.

May 26 1923 (Address) 6200 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 5/28. 1923

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Hemorrhage

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76142

CERTIFICATE OF DEATH.

44

D76142

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 N. Carey St. ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lola V. Jones

(a) RESIDENCE NO. 523 N. Carey St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Jones

6 DATE OF BIRTH (month, day, and year) Feb. 12th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles C. Sears

11 BIRTHPLACE OF FATHER (city or town) A.A.C.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Harriet V. Skinner

13 BIRTHPLACE OF MOTHER (city or town) Kent Co.
(State or country) Md.

14 Informant T. Irvin Rothel
(Address) 1016 Harlem Ave.

15 Filed MAY 28 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1st 1923 to May 25 1923.

that I last saw h[illegible] alive on May 21 1923,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uremia Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas B Kreuder, M. D.

(Address) 412 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL May 28 1923

20 UNDERTAKER Joseph B. Cook

ADDRESS 1005 N. Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76143 D76143

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1635 Dover St. St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Reginia Schwertle(Swertle)

(Residence in Baltimore: No. 1635 Dover St. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. May 8th 1846
(Month) (Day) (Year)

7-AGE. 77 yrs. 0 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE. (State or Country). Germany

PARENTS.

10-NAME OF FATHER. John Miller

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Unknown Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Reebold

(Address) 1637 N. Durham St.

15- MAY 28 1923

Filed 192 ROBERT R. KRAMER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 25th 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy, Fall down stairs, at Her Home

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(Duration) 2 yrs. mos. ds.

(Signed) James H. Fenton M. D.
(Coroner)

May 25 1923 (Address) 706 E. Chase St.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. National Cemetery DATE OF BURIAL. May 29 1923

20-UNDERTAKER Joseph B Cook ADDRESS 1003 N Gay St

N. B.—Every item of information should be carefully supplied. Note should be made of the fact that it may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that is very important. See instructions on back of certificate.

D76144

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76144

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Polytechnic School

City of BALTIMORE: (No. E. North Ave. St., 28 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James G. Dailey

(Residence in Baltimore: No. Tucker Ave. Hillsdale, Md. St., 3 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. May (Month) 26th (Day) 1877 (Year)

7-AGE.	If LESS than 1 day,
45 yrs. 11 mos. 29 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Janitor Public
(b) General nature of industry, business, or establishment in which employed (or employer): School 64 (Forest & Carrison Ave.)

9-BIRTHPLACE, (State or Country): Baltimore Co. Md.

PARENTS.

10-NAME OF FATHER, John T. Dailey

11-BIRTHPLACE OF FATHER, (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Sarah Warfield

13-BIRTHPLACE OF MOTHER, (State or Country), Westminister, Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Daisy M. Dailey

(Address) Tucker Ave. Hillsdale, Md.

15- MAY 28 1923 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 25th (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to ...death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Embolism

Heart

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.
(Coroner.)

May 26 192 3 (Address) 3632 Roland Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Lorraine Cemetery — DATE OF BURIAL, May 29 1923

20-UNDERTAKER, Joseph B. Cook — ADDRESS 1003 N. Eutaw

N. B.—Every item of information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D76145

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D76145

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 36 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph Frick

(a) Residence No. Unknown St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1847

7-AGE. 75 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Phillip Frick

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14- (Informant) Municipal Hospital Records

(Address)

15- Filed MAY 28 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 26, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 5, 1923 to May 26 1923.

that I last saw him alive on May 26 1923.

and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis; Left Hemiplegia

(Duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. M. Powell M. D.

5-26-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mount Carmel	May 28 1923
20-UNDERTAKER.	**ADDRESS.**
L. Sander Sons	1710 Pleasant St.

Exact statement of OCCUPATION is very important. See should be carefully supplied. ADE should be stated in plain terms, so that it may be properly classified. Exa instructions on back of certificates.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Apoplectic Hemiplegia

Spec.—1-10-21—M&T—1500 Bks.

D76146 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 161-002 D76146

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Agnes Hospital ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Seibo. (Boy)

(a) RESIDENCE NO. 829 Franklin Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word): single

5a If married, ~~widowed,~~ or ~~divorced~~ HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): May 21, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St Agnes Hospital Balto Md.

PARENTS

10 NAME OF FATHER: John Seibo

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant (Address): John Seibo 829 Franklin Rd

15 MAY 28 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 27 1923

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1923, to May 27, 1923, that I last saw him alive on May 27, 1923, and that death occurred, on the date stated above, at 1.00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward A. Kotlowski, M. D.

MAY 28 1923

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION~~ OR REMOVAL: London Park

DATE OF BURIAL: MAY 28 1923, 19

20 UNDERTAKER: Geo. R. Little

ADDRESS 2700 EDMONDSON AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76147

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

181-005 D76147

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 121 St. 27th St. (ST.) 9 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward A. Carey

(a) RESIDENCE NO. 121 St. 27th St. (ST.) WARD

(Usual place of abode)

Length of residence in city or town where death occurred about 56 yrs. — mos. — ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie E. Carey

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer for

(b) General nature of industry, business, or establishment in which employed (or employer) Electrical Commission

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md (State or country)

PARENTS

10 NAME OF FATHER Patrick Carey

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Alice Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mrs Annie E. Carey

(Address) 121 E. 27th St

15 Filed MAY 28 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1923

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1922, to May 26, 1923.

that I last saw him alive on May 26, 1923

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

(Coroner's Case No. 5)

Cerebral Hemorrhage

(duration) yrs. 1 mos. wks. ds.

CONTRIBUTORY (Secondary) Carbon Monoxide Poisoning

(duration) yrs. 1 mos. wks. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L. A. Richardson M. D.

(Address) 1122 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL May 29 1923

20 UNDERTAKER Henry Hoeck Son — ADDRESS 1301 E. Monument

MAY 28 1923

N. B.—All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

076148 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D76148

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1921 Patterson Place ST., 8 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer W Jenkins

(a) RESIDENCE No. 1921 Patterson Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 22 - 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	15	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wesley Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Alice Kreider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Alice Jenkins (Address) 1921 Patterson Place

15 MAY 28 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1 1919 to May 27 1923. that I last saw him alive on May 26 1923, and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Valvular Heart disease

(duration) 3 yrs. 10 mos 23 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob Joshua, M. D.

5/27, 1923 (Address) 1823 N. Wash st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: May 29 1923

20 UNDERTAKER: John Reeves — ADDRESS: 1109 Eden

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec—12-23-21—E.B.R.S.—400 Bks.

D76149 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D76149

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Municipal Hospital St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Woldsauer

(a) Residence No. 1413 Eastern Ave. St., Ward,
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1866

7-AGE. 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Umbrella Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Washington, D.C.

PARENTS.

10-NAME OF FATHER. Fred Woldsauer

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Virginia Thugle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). France

14- (Informant) Municipal Hospital Records
(Address)

15- Filed MAY 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 25, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 21 1923 to May 25, 1923 that I last saw h[im] alive on May 24 1923 and that death occurred, on the date stated above, at 7:45 A.M. The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. M. Powell M. D.

5-25-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Friendly Care	May 28 1923
20-UNDERTAKER. John Elliott	ADDRESS. 2008 Eden

Should be carefully supplied as much information in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76150

HEALTH DEPARTMENT—CITY OF BALTIMORE

X/83

D76150

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH Pronounced dead at

City of BALTIMORE: (No. Johns Hopkins Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward A. Rahn

(Residence in Baltimore: No 220 Mulberry St. Harrisburg, Pa. St.; yrs. mos. ds.)

4/8 Lno

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	married

6-DATE OF BIRTH. January 23/1855
(Month) (Day) (Year)

7-AGE. 68 yrs. 4 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Steel-worker
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Harrisburg, Pa.

PARENTS.

10-NAME OF FATHER. Harris Rahn

11-BIRTHPLACE OF FATHER, (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Ann Flynn

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William Rahn (Brother)
(Address) 1146 DERRY ST. Harrisburg

15-
MAY 28 1923
ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 26/23
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquest find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hemorrhage in thoracic cavity-
pistol shot wound- accidently
discharged while in the hands of
Clarence Haskins 317 Franklin St.
Steelton, Pa., at 3301 Phila. RD.
Balto. Md.

(CONTRIBUTORY) (Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. H. Voller M. D.
(Coroner.)
5/27/23 192 (Address) 505 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Harrisburg Pa.	May 28 1923
20-UNDERTAKER.	ADDRESS
Richard F. Cunley	108 Guilford Ave

Spec—12-23-21—E.B.R.S.—400 Bks. Drumgoole Patar 1114 Hfd. Ave.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76151 D76151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1027 Wilkens St. St., 16 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Thomas Drumgoole

(a) Residence No.... 1027 Wilkens St. St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-~~Single,~~ Married, ~~Widowed, or Divorced,~~ (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Drumgoole

6-DATE OF BIRTH (month, day and year) October

7-AGE, 53 yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Patrick Drumgoole

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Ann McGowan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant)... (Address) Mrs. F. Boyd Lee 1617 Eutaw

15- FILED MAY 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 27 1923

17- I HEREBY CERTIFY, That I attended deceased from Apr 10th, 1923 to May 27th, 1923

that I last saw him alive on May 11th, 1923

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Peritonalis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?...

Did an operation precede death? No Date of...

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) L. McCarthy M. D.

May 30, 1923 (Address) 1114 Hfd Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral — DATE OF BURIAL, May 30, 1923

20-UNDERTAKER, Wm Cook — ADDRESS 502 N Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76152

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D76152

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Roese

(Residence in Baltimore: No. 2541 E. Biddle St.; yrs. 5d mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	widow

6-DATE OF BIRTH. Nov 1852 1
(Month) (Day) (Year)

7-AGE. 71 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Germany

PARENTS

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER, (State or Country). "

12-MAIDEN NAME OF MOTHER. "

13-BIRTHPLACE OF MOTHER, (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Hennesey

(Address) 2541 E. Biddle St.

15- Filed MAY 28 1923 ROBERT R. KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 25/23
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insuffiency

(Accidentally fell in door yard on May 11th and fractured neck of rt. femur) (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Developed bed sores &c sepsis (Duration) yrs. mos. ds.

(Signed) J. H. Polen M. D.
(Coroner)

5/27/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Loudon Park DATE OF BURIAL. May 28th 1923

20-UNDERTAKER. William Poole ADDRESS 507 E North Ave

IMPORTANT—Physicians should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76153

CERTIFICATE OF DEATH.

122 D76153

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 624 Bruce St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joel A Phillips

(a) Residence No. 624 Bruce St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds How long in U. S., If of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Black

5-Single, ~~Married,~~ ~~Widowed,~~ or ~~Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Adult

7-AGE. 21 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cyclery

(b) General nature of industry, business, or establishment in which employed (or employer) U. S. G.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Jamaica

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) Benj. M. Jackson

(Address) 1105 N. Eutaw

15- FILED MAY 28 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 26/23

17- I HEREBY CERTIFY, That I attended deceased from May 21, 1923, to May 26, 1923, that I last saw h. alive on May 25, 19, and that death occurred, on the date stated above, at 3.25a m.

The CAUSE OF DEATH* was as follows:

Sclerosis of Liver

(Duration) 3 yrs. mos. dy.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. E. Lenk M. D.

May 26 (Address) 1334 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Olivet	May 28 1923
20-UNDERTAKER.	ADDRESS
William Cap	512 E Nat'l

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Alcoholic

Spec.—12-23-21—E.B.P.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76154 **CERTIFICATE OF DEATH.** 89 ✓ D76154

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 17-N-Liberty-St. St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Clinton Stieff

(a) Residence No. 104-Ridgewood-Road, St., 27 Ward (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 5 mos. 28 ds. How long in U. S., if of foreign birth? 61 yrs. 5 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Numsen Stieff

6-DATE OF BIRTH (month, day and year) Nov-28-1861

7-AGE. 61 yrs. 5 mos. 28 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Pres't of Stieff
(b) General nature of industry, business, or establishment in which employed (or employer) Co. Silversmiths (self)
(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country) Maryland

PARENTS

10-NAME OF FATHER, John L. Stieff

11-BIRTHPLACE OF FATHER (city or town) Baltimore
(State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Hannah Clifford

13-BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or Country) Maryland

14- (Informant) Mr. G. N. Stieff, (son)
(Address) 108-Ridgewood-Road, City

15- Filed MAY 28 1923 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 26 23

17- I HEREBY CERTIFY, That I attended deceased from ..., 1919, to 5/26 1923
that I last saw him alive on 5/26 1923
and that death occurred, on the date stated above, at 9 P m.
The CAUSE OF DEATH* was as follows:

Angina Pectoris
(Duration) ... yrs. one hour mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(Duration) 5 yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of —
Was there an autopsy? Yes
What test confirmed diagnosis? Clinical findings

(Signed) R. B. Gilchrist M. D.
5/27, 1923 (Address) 1002 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: May-29-23 19..

20-UNDERTAKER: [illegible] & MOWEN COMPANY (WILLIAM F. WOOD[illegible], Successor) — ADDRESS: 108 W. NORTH AVE.

Exact statement of OCCU... should be carefully supplied. Use words which are understood in plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Hoes

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76155

91-002 D76155

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 Prospect St. Roland Park 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles S. Hoes

(a) RESIDENCE. No. 122 Prospect ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired,

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture

(c) Name of employer Moore

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Granderson Hoes

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mary Myers

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Rachel Johnson
(Address) 122 Prospect Ave

15 FILED MAY 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 15: 1923, to May 25, 1923, that I last saw him alive on May 16: 1923, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis
Cerebral

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. F. Pearce M. D.

1923 (Address) 245 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 5/28/23

20 UNDERTAKER Paul Schmidt — ADDRESS 578 N Eden

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(See Letter Attached)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76156

CERTIFICATE OF DEATH.

38 D76156

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Parks

(a) RESIDENCE NO. 1523 Cole N ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr Catherine Parks

6 DATE OF BIRTH (month, day, and year): June 28-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Railroad wk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Mr Brown

9 BIRTHPLACE (city or town) (State or country): Baltimore md

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mrs Catherine Parks

(Address) 1523 Colerain Ave

15 MAY 28 1923

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26 1923

17 I HEREBY CERTIFY, That I attended deceased from May 21, 19 23, to May 26, 19 23, that I last saw h— alive on May 26, 19 23, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

myocarditis.
Arterio-sclerosis
Gangrene left leg.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 26-23

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward A. Kalawski, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: May 29 1923

20 UNDERTAKER: Geo Prosser — ADDRESS: 1442 N Gay

Blanks should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Syphilis.

St. Agnes' Hospital,
Baltimore, Md.

May 31st, 1923.

C. Hampson Jones, M. D.
Commissioner of Health,
Baltimore, Maryland.

Dear Doctor Jones : -

In regard to the death certificate of Mr. Harry A. Parks who died on May 26th, 1923, I wish to state that his wife gave his age as recorded on the certificate, 48 years, but his sister tells me that he would have been 47 on the 28th of June, 1923.

Kindly make this correction on the certificate.

Yours very truly,

E. A. Kitlowski, M.D.

E. A. Kitlowski, M. D.
Resident Surgeon.

EAK/MA

Spec.—1-10-21—M&T—1500 Bks.

Collod

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76157

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital X 101-001 ✓ REGISTERED NO. D76157

CITY OF BALTIMORE: (No. ..... ST., 7 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leon Sallod

(a) RESIDENCE NO. 541 S Arlington St. Philadelphia Pa ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 20/21

7 AGE — Years 2 — Months 1 — Days 5 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Born in Phila Pa

PARENTS

10 NAME OF FATHER Sol. Soldod

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie Levin

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Russia

14 Informant Mrs Reads (Address)

15 Filed MAY 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1923

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1923, to May 28, 1923, that I last saw her alive on May 28, 1923, and that death occurred, on the date stated above, at 10 40 A m.

The CAUSE OF DEATH* was as follows:

General Toxemia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of May 24, 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Heller Goldsmith, M.D.

, 19 (Address) Hebrew Hosp. City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phila Pa — DATE OF BURIAL May 28 1923

20 UNDERTAKER Jack Lewis — ADDRESS 1439 Fairmount Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76158

CERTIFICATE OF DEATH.

Incorrectly 27

90 D76158

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1 E. Southern Ave. ST., 27 WARD)

2-FULL NAME Charles Raulader

(a) RESIDENCE No. 1 E. Southern Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of ~~or Wife of~~ Bertha Raulader

6 DATE OF BIRTH (month, day, and year) June 5. 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) Wunsenden (State or country) Germany

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louise Singer (Address) 1 E. Southern Ave.

15 MAY 28 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1923

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to May 26, 1923, that I last saw him alive on May 25, 1923, and that death occurred, on the date stated above, at 2:50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Organic heart disease

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? principal physical signs

(Signed) Chester Riland, M. D.

5-26, 1923 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	May 30 1923
20 UNDERTAKER Wm Tickner & Sons	ADDRESS Norfolk Va

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.F.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76159

CERTIFICATE OF DEATH.

101-001 D76159

1-PLACE OF DEATH

Registered No. .....

City of BALTIMORE: (No. 3536 Poole St, 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Harry Barnes

(a) Residence No. 3536 Poole St, Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 5 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. White

5-~~Single, Married, Widowed, or Divorced.~~ Single (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 4 1916

7-AGE. 6 yrs. 5 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Child

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER. Clarence Barnes

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Viola Hurt

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va

14- (Informant) Amos Barnes

(Address) 3536 Poole St

15- Filed MAY 28 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 27 1923

17- I HEREBY CERTIFY, That I attended deceased from May 5 1923 to May 27 1923

that I last saw h[illegible] alive on May 27 1923

and that death occurred, on the date stated above, at 11 A M

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Tobacco Amblyopia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Was an operation preceds death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Examination

(Signed) C. J. Davies M. D.

5-28, 1923 (Address) 800 W 33rd St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Marys Hampden	May 29 23
20-UNDERTAKER.	ADDRESS
Chenoweth & Son	Chestnut Ave

In order that certificate may be properly classified, See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76160 11-002 D76160

CERTIFICATE OF DEATH.

D76160

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 Luzerne Ave. St. North WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo Hoehl

(a) RESIDENCE NO. 536 Luzerne Ave St. North WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frances Hoehl

6 DATE OF BIRTH (month, day, and year): Jan 6th 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Bavaria

PARENTS

10 NAME OF FATHER: G. Hoehl

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bavaria

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Francis Hoehl
(Address): 536 N. Luzerne Ave

15 MAY 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26th 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1923, to May 26, 1923, that I last saw h in alive on May 26, 1923, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1/2 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? symptoms

(Signed) Alma B Lemmon M. D.

5/28 1923 (Address) 918 N. Pulaski Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL: May 29 1923

20 UNDERTAKER: Geo M. Fluck Son — ADDRESS: 811 N Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76161

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76161

CERTIFICATE OF DEATH. 7H-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 883 Raborg ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pinkney Smith

(a) RESIDENCE NO. 883 Raborg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col.	Mar.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER May Brann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Cordelia Hughes

(Address) 736 Raborg

15 Filed MAY 28 1923 ROBERT R. KRAUTER, Register

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1923

17 I HEREBY CERTIFY, That I attended deceased from May 22, 19 23, to May 26, 19 23,

that I last saw h alive on May 25, 19 23

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Morrow, M. D.

19 (Address) 939 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL May 29 1923

20 UNDERTAKER R. L. Parham — ADDRESS 902 Leadenhall St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76162

CERTIFICATE OF DEATH.

31

D76162

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1619 Montpelier St St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecial Virginia Fowler

(a) Residence No. 1619 Montpelier St St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of William H Fowler

6-DATE OF BIRTH (month, day and year) May 16 1865

7-AGE, 58 yrs. mos. 10 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Delaware

PARENTS

10-NAME OF FATHER, Richard Taylor

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Delaware

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Edith I DeGraw

(Address) 1619 Montpelier St

15- Filed MAY 28 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 26 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 1922 to May 26 1923

that I last saw her alive on May 25 1923

and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows:

1 Pulmonary Tuberculosis

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. J. Kinzer M. D.

May 27 1923 (Address) 2700 Hartford Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Wesley Chapel Ken Co Md. DATE OF BURIAL. May 29 1923

20-UNDERTAKER. Harry Hellmann ADDRESS 4204 Ridgewood Ave

Exact statement of OCCUPATION is very important. See instructions on back of certificates. Unless the CAUSE OF DEATH is properly stated, and the MODE OF DEATH is clearly described in plain terms, so that it may be properly classified.

Spec.—1-10-21 M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D76163

CERTIFICATE OF DEATH.

117

D76163

1-PLACE OF DEATH Maryland Central Hospital

CITY OF BALTIMORE: (No. ..... St., 14 Ward)

REGISTERED NO. D76163

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Buggles

(a) RESIDENCE No. 8 N. Gilmor ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 23 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brakesman

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John H. Buggles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lila Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wilhelmina Carl
(Address) 8 N. Gilmor st

15 MAY 28 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1923

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1923, to May 26, 1923, that I last saw h[illegible] alive on May 26, 1923, and that death occurred, on the date stated above, at 6.50 a m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

Acute Peritonitis

(duration) yrs. ..... mos 36 ds.

CONTRIBUTORY (Secondary) Pulmonary Abscess

(duration) yrs. ..... mos. 9 ds.

18 Where was disease contracted If not at place of death? At home

Did an operation precede death? Yes Date of May 1-1923

Was there an autopsy?

What test confirmed diagnosis? Clinically

(Signed) James H. Allison, M. D.

(Address) M.d. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK	May 29 23
20 UNDERTAKER	ADDRESS
Robert Brookseier	Calhoun Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76164

CERTIFICATE OF DEATH.

REGISTERED NO. C 90 D76164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 University Parkway ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Cline

(Residence in Baltimore: No. 912 University Parkway St.: 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Dec 25 (Month) (Day), 1844 (Year)

7-AGE, 8 yrs. mos. 1 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Clara Coates

(Address) 912 University Parkway

15-

Filed MAY 28 1923 191. ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 24 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 24 1923, to May 25 1923, that I saw her alive on May 24 1923 and that death occurred, on the date stated above, at 7:10 P m.

The CAUSE OF DEATH* was as follows:

Paralysis, Myocarditis

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(Duration) yrs. mos. 3 ds.

(Signed) C. Lehman Donnell M. D.

May 25, 1923 (Address) 517 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL, May 29, 1923

20-UNDERTAKER J. E. Stuples

ADDRESS 1417 W. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Edward W. Marley. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76165

CERTIFICATE OF DEATH.

161-001

D76165

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 410 Fort Hill ave ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward W. Marley

(a) RESIDENCE NO. 410 Fort Hill ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. 12 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 10. 23.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
			17.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward F. Marley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Florence Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mother Florence Marley

(Address) 410 Fort Hill Ave.

15 Filed MAY 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27. 1923

17 I HEREBY CERTIFY, That I attended deceased from May 12. 1923, to May 27 1923, that I last saw him alive on May 27 1923 and that death occurred, on the date stated above, at 2 P.M. a. m.

The CAUSE OF DEATH* was as follows:

Premature Birth. 6 months

Hyn

(duration) yrs. mos 17. ds.

CONTRIBUTORY (Secondary) Convulsions.

(duration) yrs. mos. 2. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No

What test confirmed diagnosis? Dr. Wilson

(Signed) Dr. H. Wilson M. D.

, 19 (Address) 330 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL May 28 1923

20 UNDERTAKER Geo. L. Schwab ADDRESS 1101 Fulton Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76166 | 31 | D76166

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Glasper

(a) RESIDENCE NO. 505 Mosher st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Edward Glasper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) M. T. H.

15 Filed MAY 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1923, to May 26, 1923, that I last saw him alive on May 26, 1923, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Daley M. D.

5-26-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	May 30 23
20 UNDERTAKER James H. Lewis	ADDRESS 1203 Pennsylvania

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D76167

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76167

CERTIFICATE OF DEATH.

31

REGISTERED NO. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1705 Ditman Court St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elsie Talbot

(Residence in Baltimore: No. 1705 Ditman Court, St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) single

6-DATE OF BIRTH, about ..... (Month) ..... (Day) 1900 (Year)

7-AGE, 23 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Home Duties
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Emanuel Talbot

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Ann Darcy

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John L. Reynolds

(Address) 1705 Ditman Ct.

15- MAY 28 1923 Filed ..... 191.....

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 25, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Tuberculosis

(Duration) ..... yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.) M. D.

May 27, 1923 (Address) 250 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Pikesville

DATE OF BURIAL, May 29 1923

20-UNDERTAKER, Henry A. Davis

ADDRESS, 2203 Druid

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76168

100-001

D76168

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 Burgundy alley ST. 22 WARD)

2-FULL NAME Edward Daily

(a) RESIDENCE NO. 507 Burgundy st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 10 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7 Month	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Nom.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balt md
(State or country)

PARENTS

10 NAME OF FATHER Henry Daily

11 BIRTHPLACE OF FATHER (city or town) md
(State or country)

12 MAIDEN NAME OF MOTHER Edith Hawkins

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) md

14 Informant Henry Daily
(Address) 507 Burgundy st

15 Filed MAY 28 1923 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W R Grumpley, M. D.
(Coroner.)

May 28, 1923 (Address) 117 W Saratoga st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	May 28 192
20 UNDERTAKER	ADDRESS
Bro Scott Hooper & Co	

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76169

D76169

CERTIFICATE OF DEATH.

188-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. B & O R R tracks, near Lead enhall St. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Daniel Kritz.

(a) RESIDENCE NO. 148 N. Curley ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? 20 yrs. --- mos. --- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kritz.

6 DATE OF BIRTH (month, day, and year) July 17, 1870.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	52	10	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Gas & Electric Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria.

PARENTS

10 NAME OF FATHER Martin Kritz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria.

12 MAIDEN NAME OF MOTHER Mary A. Reif

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria.

14 Informant Mary Kritz (wife). (Address) 148 N. Curley St.

15 Filed MAY 28 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26. 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Run over and mangled by Engine
No. 4337 B & O R R Co.
Accidental death.
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)
May 27, 1923 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL May 29 1923

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 W. Mulberry St.

IMPORTANT—Should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D76170

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D76170

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 E. Monument ST.; WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Jones

(Residence in Baltimore: No. 1502 E. Monument St. 35 yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH. unknown (Month) (Day), 1855 (Year)

7-AGE 68 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER Lettie Fortune

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Henderson (daughter)

(Address) 1502 E. Monument St

15-

Filed Robert P. Harrison, Registrar.

MAY 28 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 27 (Day), 1923 (Year)

17-I HEREBY CERTIFY, That I attended deceased from ~~March~~ April 1923, to May 27 1923, that I saw her alive on May 27 1923, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency and Pericardial Effusion Septic

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. J. Young M. D.

5/27, 1923 (Address) 1429 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Chance Va

DATE OF BURIAL, May 29, 1923

20-UNDERTAKER John W Henderson

ADDRESS 1502 E. monument St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

D76171

HEALTH DEPARTMENT—CITY OF BALTIMORE

Health

90 D76171

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1038 Hanover St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Antonia A. Krebs

(Residence in Baltimore: No. 1038 Hanover St. St. 74 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

6-DATE OF BIRTH, June (Month) 23 (Day) 1849 (Year)

7-AGE. 58 yrs. 11 mos. 1 ds. If LESS than 1 day, ...hrs. or.... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. At Home
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country). "

12-MAIDEN NAME OF MOTHER, "

13-BIRTHPLACE OF MOTHER, (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Natalie Krebs, Daughter in law

(Address) 1017 Asquith St

15- Robert F. Harrison

Filed ..... 192... Burial Permit Clerk. Registrar.

28 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 24 or 25 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Portally Chronic Myocarditis

Endocarditis.

Buried at Holy Redeemer May 28 1923

10/13 (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. S. H. Waller M. D.

(Coroner)

5/28 1923 (Address) 506 E North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Cemy

DATE OF BURIAL. May 28 1923

20-UNDERTAKER. Henry Hough Son

ADDRESS 1301 E Eager St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D76172

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76172

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1717 Cloverdale Rd ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Israel Winakur

(a) RESIDENCE No. 1217 Cloverdale Rd ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dora Winakur

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 73 Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Nathan

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: Sarah

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Interment (Address): Jack Levin 1439 E Baltimore St.

15 1923 May 28 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1923

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1923, to May 28, 1923, that I last saw her alive on May 28, 1923, and that death occurred, on the date stated above, at 10:15 a.m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage (apoplexy) (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? ~~Clinical~~ No

What test confirmed diagnosis? clinical

(Signed) J. Frederick Lerch, M. D.

5/28, 1923 (Address) 1040 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: 5-28 1923

20 UNDERTAKER: Jack Levin — ADDRESS: 1439 E Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

28

Spec– 12-23-21–E.B.R.S.–400 Bks.

D76173 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76173

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH Registered No.

City of BALTIMORE: (No. Mercy Hospital St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Popp

(a) Residence No. 3500 E. Madison St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Popp

6-DATE OF BIRTH (month, day and year) Jan. 16 1879

7-AGE. 44 yrs. 4 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Painter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore Md.
(State or Country)

PARENTS

10-NAME OF FATHER, John Popp

11-BIRTHPLACE OF FATHER (city or town) Baltimore
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Cordelia Simpson

13-BIRTHPLACE OF MOTHER (city or town) Md.
(State or Country),

14- (Informant) Carrie Popp
(Address) 3500 E. Madison St

15- Robert P. Harrison, Registrar.

28 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 26 '23

17- I HEREBY CERTIFY, That I attended deceased from May 5 1923 to May 26 1923

that I last saw h... alive on May 26 1923

and that death occurred, on the date stated above, at 1.40 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Dreming.

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs + Symptoms

(Signed) J. E. Swaggerty, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Bolt | DATE OF BURIAL, May. 29 1923

20-UNDERTAKER. John Dreming | ADDRESS 2908 Greenmount

Please write plainly with pen and ink. Cause of death must be properly classified. Exact statement of OCCUPATION is very important. Use only standard terms, as given in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76174 D76174

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 N. Bond St., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Georgia

2-FULL NAME James Cherry

(a) RESIDENCE NO. 213 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Lithuania Davis

6 DATE OF BIRTH (month, day, and year): Jan. 28 1900

7 AGE: Years 23 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Dubllon County Ga.

PARENTS

10 NAME OF FATHER: James Cherry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dubblon Co ga

12 MAIDEN NAME OF MOTHER: Wilpritale

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Warrac Co Ga

14 Informant: Fannie Cherry

(Address) 213 N Bond St

15 Filed: May 28 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1923, to May 25, 1923, that I last saw him alive on May 25, 1923, and that death occurred, on the date stated above, at 5:35 p m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Acute bronchitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno O Robinson M. D.

(Address) 1530 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bay View cemetery

DATE OF BURIAL: 29 May 1923

20 UNDERTAKER: Edward Bryan

ADDRESS 1631 Orleans St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76175

CERTIFICATE OF DEATH.

124 D76175

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 Bruce ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christina. Gayo.

(a) RESIDENCE NO. 523 Bruce ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christopher Gayo

6 DATE OF BIRTH (month, day, and year) Mar. 18. 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Austria (State or country)

PARENTS

10 NAME OF FATHER John Johann

11 BIRTHPLACE OF FATHER (city or town) Austria. (State or country)

12 MAIDEN NAME OF MOTHER Annie Schisley

13 BIRTHPLACE OF MOTHER (city or town) Austria (State or country)

14 Informant Christopher Gayo. (Address) 523 Bruce St

15 MAY 28 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1923

17 I HEREBY CERTIFY, That I attended deceased from May 3 1923 to May 27 1923 that I last saw h alive on May 26 1923 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) B. G. Ware M. D.

May 27 1923 (Address) 801 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	May 29 1923
20 UNDERTAKER Margaret A. Flynn	ADDRESS 1421 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Hypertrophy Liver

492 – 34

2653 – V4

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76176 ✓ D76176

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 Hanover St. 23 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Nancy Patti

(a) RESIDENCE NO. 914 Hanover St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel J. Patti

6 DATE OF BIRTH (month, day, and year): Sept 4 1904

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
19	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Laureto Insenga

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Francis Ferraro

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Samuel Patti

(Address): 914 Hanover St

15 Robert P. Harrison, . 19 Registrar

Burial Permit Clerk.

MAY 28 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 27/23

17

I HEREBY CERTIFY, That I attended deceased from May 15/23, 19, to May 27/23, 19.

that I last saw him alive on May 26/23, 19.

and that death occurred, on the date stated above, at 3:20 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Thrombo Embolism

Primal Cardiac (duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) H. B. Hoff, M. D.

(Address) 120 High St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 5/29/1923

20 UNDERTAKER: Margaret E. Flynn

ADDRESS: 1427 Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

D76177 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76177

CERTIFICATE OF DEATH. 9 X 31

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. St. Joseph Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fay C. Martin

(Residence in Baltimore: No. Darlington Md St.; yrs. mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
female	white	Married

6-DATE OF BIRTH. January 8/1898, 1..... (Month) (Day) (Year)

7-AGE. 25 yrs. 4 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Ash Co. N.C.

PARENTS.

10-NAME OF FATHER. F.H.Hash

11-BIRTHPLACE OF FATHER, (State or Country). Grayson Co. Va.

12-MAIDEN NAME OF MOTHER, Eliza Kirk

13-BIRTHPLACE OF MOTHER, (State or Country). Grayson Co. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F.H.Hash(Father)

(Address).....

15-

MAY 28 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 28/23, 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insuffiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (Duration) yrs. 3 or 4 mos. ds.

(Signed) J. Stiff Coulter M. D. (Coroner)

5/28/23 192.... (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Darlington Md

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Darlington Md. May 30, 1923

20-UNDERTAKER. ADDRESS
H.L. Bailey Darlington, Md.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

(Yinger)

76178 ✓ 76178

D76178 HEALTH DEPARTMENT—CITY OF BALTIMORE D76178

93

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St Agnes Hospital ST., 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie Yinger

(a) RESIDENCE NO. 2522 Guilford Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE white

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Yinger

6 DATE OF BIRTH (month, day, and year) May 27-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md (State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant August Yinger

(Address) 2522 Guilford Ave

15 MAY 28 1923 Robert F. Carrick, Registrar

Burial Permit Clerk. 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1923

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1923, to May 27, 1923, that I last saw he alive on May 27- 1923, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Thrombo Phlebitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Edward A. Kotarski, M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL May 30 1923

20 UNDERTAKER Harry H Metzler — ADDRESS 1538 Madison Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Infected ~~from~~ varicose veins.

Spec.—1-10-21—M&T—1500 Bks.

D. 76179 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 76179

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~128~~ St Agnes Hospital St.. WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry W. Mercer

(a) RESIDENCE NO. 128 Son Gilmor St ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE White

5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word) Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) — 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21 -	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Not Known

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Jessie Mercer
(Address) 128 - son Gilmor

15 Robert P. Harrison, Registrar
MAY 28 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1923

17 I HEREBY CERTIFY, That I attended deceased from May 14 1923, to May 27 1923, that I last saw him alive on May 27 1923, and that death occurred, on the date stated above, at 10:15 Am m.

The CAUSE OF DEATH* was as follows:

Subacute bacterial endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Karl J. Steinmeller M. D.

5/7, 1923 (Address) 327 N. Carrollton Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Md — DATE OF BURIAL May 30 1923

20 UNDERTAKER Harry R. Metzke — ADDRESS 1531 Pontiac St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Rheumatic fever.

Spec.—1-10-21—M&T—1500 Bks.

D76180

HEALTH DEPARTMENT—CITY OF BALTIMORE

12 ✓ D76180

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1219 N. Cross St.

CITY OF BALTIMORE: (No. 1219 N Cross St ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Shanks

(a) RESIDENCE No. 1219 N. Cross St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin Shanks

6 DATE OF BIRTH (month, day, and year) June 7 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Stephen J Roach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Isabell O'Neil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mamie Santmeyer

(Address) 1219 N. Cross St

15 MAY 28 1923 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 19 23.

17

I HEREBY CERTIFY, That I attended deceased from May 14, 19 23. to May 24, 19 23.

that I last saw h[illegible] alive on May 24, 19 23.

and that death occurred, on the date stated above, at 7.50 P. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. F. Hennessy, M. D.

(Address) 780 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fourth Baptist — DATE OF BURIAL May 29 1923

20 UNDERTAKER Harry H Nitzke — ADDRESS 1531 N Fulton Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S date CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76181

CERTIFICATE OF DEATH. X 74-001

D76181

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen Hosp St., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James R Glass

(a) RESIDENCE NO. Massey Md St., WARD Massey Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Laura Glass (nee Smith)

6 DATE OF BIRTH (month, day, and year) April 16 - 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	65	1	9	

8 OCCUPATION OF DECEASED Manager

(a) Trade, profession or particular kind of work Canner

(b) General nature of industry, business, or establishment in which employed (or employer) Canning Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Thos. Glass

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Sarah Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Thomas Glass
(Address) 1819 N. Bond St

15 5/28 1923 Robert F. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-25- 1923

17 I HEREBY CERTIFY, That I attended deceased from 5-11-23, 19..., to 5-25-23, 19...,
that I last saw him alive on 5-25-23, 19...,
and that death occurred, on the date stated above, at 9:00 a. m.
The CAUSE OF DEATH* was as follows:

Appendicitis

2 hrs
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Jno. A. Tompkins, M. D.

, 19 (Address) Md Gen Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Perryman Md. DATE OF BURIAL: May 29 1923

20 UNDERTAKER: Harry H Witzke ADDRESS: 1521 W. Lombard St.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76182

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76182

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 Calvin ST.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie Thomas

(a) RESIDENCE. No 113 Calvin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, ~~Married, Widowed~~ or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 40 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER Wm Thomas.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Dora Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Dora Thomas. (Address) 110 Calvin

15 Filed Robert P. Harrison, Registrar

MAY 28 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1923

17 I HEREBY CERTIFY, That I attended deceased from May 25 1923, to May 26 1923, that I last saw h[er] alive on May 26 1923 and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Brights Dis

(duration) yrs. mos. 1d ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Clyde Dennis, M. D.

1923 (Address) 2218 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel

DATE OF BURIAL: May 29 1923

20 UNDERTAKER: Geo P. Furst Manage

ADDRESS: Albany 2[d] 2626 Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificates.

Spec.–1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76183

CERTIFICATE OF DEATH.

1118-001 D76183

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (WARD)

2-FULL NAME Mrs. Agnes Inglehart

(a) RESIDENCE No. Elkridge Md. St. WARD Elkridge Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~yrs.~~ ~~mos.~~ How long in U. S., if of foreign birth? ~~yrs.~~ mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James W. Inglehart

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer ~~—~~

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Chas. Gerwig

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Phifer

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Hospital Records.
(Address)

15 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 1923

17 I HEREBY CERTIFY, That I attended deceased from 3:30 PM May 28, 1923 to 8:05 PM May 28, 1923

that I last saw her alive on May 28, 1923

and that death occurred, on the date stated above, at 8:05 P m.

The CAUSE OF DEATH* was as follows:

Strangulated right Femoral Hernia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? yes Date of May 28, 1923.

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) B. M. Rhodes, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Johns Ellicott City

DATE OF BURIAL May 30 1923

20 UNDERTAKER Easton Sons

ADDRESS Ellicott City

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76184 D76184

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2008 W. Lafayette Ave 16 12 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabella B Mathiot

(a) Residence No. 2008 W. Lafayette Ave Ward

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? 73 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE White | 5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) About

7-AGE 73 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER Augustus M Mathiot

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER Mary Hodges

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) Augusta Stanton

(Address) 106 Rosalind Ave

15- MAY 29 1923 Filed ROBERT R. KRAUTER Registrar Burial Permit Clerk

Roloth 728 W Nalbert

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 27 23

17- I HEREBY CERTIFY, That I attended deceased from March 1923 to May 1923 that I last saw h. alive on May 27 1923 and that death occurred, on the date stated above, at 4.30 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H L Roloth M D

, 19 (Address) 728 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Greenmount Cem | DATE OF BURIAL, May 29 1923

20-UNDERTAKER, William Cook | ADDRESS 502 Edmondson Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76185 HEALTH DEPARTMENT—CITY OF BALTIMORE D76185

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 4 9 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara E. FIZER

(Residence in Baltimore: No. 776 Sarah Ann St.; yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced (Write the word.)
female	black	Single

6-DATE OF BIRTH. SEpt 1922 1 (Month) (Day) (Year)

7-AGE. yrs. 8 mns. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Balto. Md.

PARENTS

10-NAME OF FATHER. Peter Fizer

11-BIRTHPLACE OF FATHER, (State or Country) Md

12-MAIDEN NAME OF MOTHER. Annie Bomish

13-BIRTHPLACE OF MOTHER, (State or Country) Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Hopkins Hospital

(Address)

15- MAY 29 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 26/23 192.. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pertussis

CAutopsy at hospital

(Duration) yrs. 12 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 5 ds.

(Signed) J S Phelan M. D. (Coroner)

5/28/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem DATE OF BURIAL. 5-29- 1923

20-UNDERTAKER. David Easter ADDRESS 976 Pa ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76186 49 D76186

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE, (No. 1008 Mosher St., 16 Ward) Registered No.

2-FULL NAME Earnest Meade

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1008 Mosher St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth Meade

6-DATE OF BIRTH (month, day and year) Feb. 22-1899

7-AGE. 34 yrs. 3 mos. 5 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (City or Town) (State or Country), New Kent Co. Va

PARENTS.

10-NAME OF FATHER Henson Meade

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER Atkinson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) Ruth Meade

(Address) 1008 Mosher St

15- Filed MAY 29 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 27. 1923

17- I HEREBY CERTIFY, That I attended deceased from March 29 1923 to May 27 1923

that I last saw him alive on May 27 1923

and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Sarcomatosis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Johns Hopkins

(Signed) John K. Cassady M. D

, 19 (Address) 5 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Sweet Air Md | DATE OF BURIAL 5/29 1923

20-UNDERTAKER Samuel Kennedy | ADDRESS W Biddle

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough. Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Cancer of Arm

Spec.—1-10-21—MAT—1500 Blks.

D76187

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76187

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 526 Pine St ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Anderson

(a) RESIDENCE NO. 526 Pine St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): may 28 1921

7 AGE: 2 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Olivia Yancy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Olivia Yancy (Address) 526 Pine St

15 MAY 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/27/ 1923

17 I HEREBY CERTIFY, That I attended deceased from March 23 1923, to May 27 1923, that I last saw him alive on May 25, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) yrs. 2 mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Howell Jones M. D.

5/28/23 (Address) 1619 Arrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cemetery Es Mt auburn

DATE OF BURIAL: may 1923

20 UNDERTAKER: Edward Bryan

ADDRESS 1621 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76188

CERTIFICATE OF DEATH.

101-001 D76188

1-PLACE OF DEATH

City of BALTIMORE: (No. 613 West Ave St., Arcadia 27 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Edna Netzke

(a) Residence No. 613 West Ave St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. — mos. — ds. How long in U. S., if of foreign birth? 32 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Netzke

6-DATE OF BIRTH (month, day and year) July 30th 1891

7-AGE, 31 yrs. 9 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), City

PARENTS.

10-NAME OF FATHER, Chas Hartman

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), City

12-MAIDEN NAME OF MOTHER, Mary Schwinsberg

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), City

14- (Informant) Mr Henry Netzke

(Address) 613 West Ave

15- MAY 29 1923 Filed ..... 192.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 27 / 23

17- I HEREBY CERTIFY, That I attended deceased from May 8 1923 to May 27 1923

that I last saw her alive on May 26 1923

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... yrs. ... mos. 20 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. A. Neer M. D.

5/29/1923 (Address) 408 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Parkwood — DATE OF BURIAL, May 30 1923

20-UNDERTAKER, Peter Nicolaus — ADDRESS 2060 Eastern Ave

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

D76189

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D76189

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 N. Duncan ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Shields

(Residence in Baltimore: No. 508 N Duncan st St. 25 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, ~~Aug~~ Unknown, 1878
(Month) (Day) (Year)

7-AGE, 45 appx yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Jane Muse

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Matthews (son in law)

(Address) 125 W Henrietta St.

15-

FILED MAY 29 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 26, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 1923, to May 26 1923, that I saw her alive on May 26 1923, and that death occurred, on the date stated above, at 4:30 PM.

The CAUSE OF DEATH* was as follows:

Pulm T.B.

(Duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

5/27, 1923 (Address) 1124 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn cemetery DATE OF BURIAL May 29 1923

20-UNDERTAKER Milton Davis ADDRESS 315 N Eden st

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76190

CERTIFICATE OF DEATH.

128 D76190

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 723 N Lemmington ST., 4 WARD)

(If death occurred in a hospital or insttitution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edwin F. Slater

(a) RESIDENCE NO. 723 N. Lemington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W Male	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 3 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brass moulder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) Laurel Md
(State or country)

PARENTS

10 NAME OF FATHER M. Slater

11 BIRTHPLACE OF FATHER (city or town) Laurel Md
(State or country)

12 MAIDEN NAME OF MOTHER Dorothy Brown

13 BIRTHPLACE OF MOTHER (city or town) Laurel Md
(State or country)

14 Informant Mildred Scott
(Address) 1200 Glyndon ave

15 MAY 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, ~~autopsy or~~ inquiry.) thereon and from the evidence obtained by said (Inquest, ~~or~~ inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis & Pneumonia
Contributory Alcoholism
(duration) yrs. mos 5 ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos ds.

(Signed) W K Gonzales, M. D.
(Coroner.)
5-29-1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem — DATE OF BURIAL 5/31 1923

20 UNDERTAKER Robert V Brooks & Son — ADDRESS Calhoun Hoffman

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D76191

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001.

D76191

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 623 S. Kenwood Ave. 1 WARD)

2-FULL NAME Ella Levy.

(a) RESIDENCE No. 623 S. Kenwood Ave. 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Ralph Levy.

6 DATE OF BIRTH (month, day, and year) Nov. 25th 1861

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
61	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Wilkesbarre Pa.
(State or country)

PARENTS

10 NAME OF FATHER William McDermott

11 BIRTHPLACE OF FATHER (city or town) Pa.
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant Ralph Levy.
(Address) 623 S. Kenwood Ave.

15 MAY 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26th 1923

17 I HEREBY CERTIFY, That I attended deceased from 5/25, 193.. to 5/26, 1923.

that I last saw her alive on 5/26, 1923

and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C A Reifschneider, M. D.

5/27, 1923 (Address) 2959 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	May 29th 1923
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wash. Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D76192

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D76192

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. near 1721 Maryland ave or ~~ave~~ at near ~~on~~ corner of Mary land ave St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas. H Winslow

(Residence in Baltimore: No. 1726 Maryland St., 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widower, or Divorced. (Write the word.)
Mall	Col	Married

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7-AGE 48 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Lab.
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

9-BIRTHPLACE. (State or Country) Virginia

PARENTS

10-NAME OF FATHER. Henry Winslow

11-BIRTHPLACE OF FATHER. (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Carmelia Perkins

13-BIRTHPLACE OF MOTHER. (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ~~Henry Winslow~~

(Address) Elias Madden

15- Filed MAY 29 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 25 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration) yrs. mos. ds.

(Signed) ~~illegible~~ M. D.
(Coroner.)

May 28 1923 (Address) 1627 Bruce

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death. 1 yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Laurel Cemetery May 29. 1923

20-UNDERTAKER. ADDRESS 1725
Wm Robert & Elliott Ashland Va

Any supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D76193

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 ✓ D76193

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Williams

(a) RESIDENCE NO. 633 Pierce St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Jack Dix

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ruth Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Municipal Hospital Records.
(Address)

15 MAY 29 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1923, to May 26, 1923, that I last saw her alive on May 25, 1923 and that death occurred, on the date stated above, at 5:30 A. M.

The CAUSE OF DEATH* was as follows:

Edema of lungs

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Uraemia & Gangrene of left leg (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? Yes Date of 5/24/23

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) A. M. Shipley, M. D.

5-26-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 29 1923
20 UNDERTAKER	ADDRESS
R B Gross	1405 McElderry

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76194

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76194

118-602

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Joseph's Hospital St. WARD)

2-FULL NAME Mary A. Rothenberger.

(a) RESIDENCE NO. 112 N. Milton Ave St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. 8 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Peter J. Rothenberger

6 DATE OF BIRTH (month, day, and year): Sept. 14th 1867

7 AGE: Years 55 Months 8 Days 13 If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: John Stump

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Easter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Peter J. Rothenberger

(Address): 112 N. Milton Ave

15 Filed MAY 29 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 27 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1923 to May 27 1923.

that I last saw her alive on May 27, 1923.

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Yes Date of May 17, 1923.

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Jos. A. Schenck M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: May 31st 1923

20 UNDERTAKER: Lilly & Zieler — ADDRESS: 4038 Wash

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76195

D76195

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2409 Eutaw Place St. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joel Gundersheimer

(a) RESIDENCE No. 2409 Eutaw Place ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) Student

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Philip Gundersheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Carrie Bergman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mr. Philip Gundersheimer

(Address) 2409 Eutaw Place

15 MAY 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/29/1923

17

I HEREBY CERTIFY, That I attended deceased from Jan - 1922 to May 29 1923.

that I last saw h alive on May 29 1923.

and that death occurred, on the date stated above, at 4 30 A m.

The CAUSE OF DEATH* was as follows:

End. Carditis

Chronic Nephritis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Angina Pectoris, Phlebitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? City

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Joseph E. Sidlick M. D.

(Address) 3516 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem.

DATE OF BURIAL 5/30/1923

20 UNDERTAKER David Sondheim

ADDRESS 118 20 W. Mt. Royal Ave.

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76196

CERTIFICATE OF DEATH.

31 D76196

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 704 Bruce ST. 17 WARD)

2-FULL NAME Dorothy Savage

(a) RESIDENCE NO. 704 Bruce ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX — 4 COLOR OR RACE: Female, Colored — 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 0170

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): md

PARENTS

10 NAME OF FATHER: George Savage

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Edith Addison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant (Address): Martha Dorothy 704 Bruce St

15 Filed MAY 29 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-27-1923

17 I HEREBY CERTIFY, That I attended deceased from 3-2-, 1923, to 5-27-, 1923, that I last saw her alive on 5-24-, 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lungs

Independent (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jno. B. Cargill, M. D.

5-29-1923 (Address) 611-N- Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Md Auburn Cem. | DATE OF BURIAL: May 30 1923

20 UNDERTAKER: George K. Holland | ADDRESS: 163 N. Eutaw

Spec.—1-10-21—M&T—1500 Bks.

D76197

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76197

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Annapolis Road St. near Mount Olivet Cemetery WARD)

REGISTERED NO. 38

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Rollins

(a) RESIDENCE No. Annapolis Road ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cora Rollins

6 DATE OF BIRTH (month, day, and year): -? ?1879

7 AGE — Years: 44 — Months: ? — Days: ? — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Catonsville Balto Co Md

PARENTS

10 NAME OF FATHER: George D. Rollins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick City Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: George Rollins

(Address) 827 Lemmon St

Filed MAY 29 1923 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26 1923

17 I HEREBY CERTIFY, that I attended deceased from May 18, 1923, to May 26, 1923, that I last saw him alive on May 24, 1923, and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Valvulotis

(duration) Indeterminate ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) Indeterminate ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. F. Hoyer M. D.

5/28, 1923 (Address) 119 N Carrollton Ave

*(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: May 29, 1923

20 UNDERTAKER: Burns & Eichenlaub — ADDRESS 1140 Lexington

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D 76198

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 76198

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2326 Madison ave. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary S. Faust

(a) Residence No. 2326 Madison ave. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Fem.	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 23, 1843

7-AGE. 79 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country),

PARENTS.

10-NAME OF FATHER, John Wadner

11-BIRTHPLACE OF FATHER (city or town) Germany (State or Country),

12-MAIDEN NAME OF MOTHER, Caroline Steinmeyer

13-BIRTHPLACE OF MOTHER (city or town) Germany (State or Country),

14- (Informant) Louis S. Faust (daughter)

(Address) 2326 Madison ave.

15- Filed 1923 Robert P. Harrison, Registrar.

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 28, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 7 1923 to May 28, 1923, that I last saw h[illegible] alive on May 28 1923, and that death occurred, on the date stated above, at 8:50 a. m.

The CAUSE OF DEATH* was as follows:

Heart disease

Hypocardiitis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? physical exam. autopsy

(Signed) L. X. Sherwell, M. D.

May 28, 1923 (Address) 2226 Madison ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	May 31 1923
20-UNDERTAKER.	ADDRESS
George J. Smith	1532 Hollins st

29 1923

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

In plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

(George Mills)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76199

CERTIFICATE OF DEATH.

90 ✓ D76199

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1514 Lemmon ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo Mills

(a) RESIDENCE NO. 1514 Lemmon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C	Mar

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince Georges Co

PARENTS

10 NAME OF FATHER Henry Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince Georges Co

12 MAIDEN NAME OF MOTHER Jane Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince Georges Co

14 Informant Hester Mills

(Address) 1507 Lemmon St

15 MAY 29 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 19 23, to May 28, 19 23, that I last saw h alive on May 28, 19 23, and that death occurred, on the date stated above, at 7 20 P m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Pulm. Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Norwood, M. D.

May 29, 19 (Address) 937 W Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 30 1923

20 UNDERTAKER Brown & Copeland Schuster ADDRESS 114 W

N. B.—All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76200

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D76200

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 N Calhoun 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby McThurston

(a) RESIDENCE NO. 1003 N. Calhoun ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced. (write the word) ~~Divorced~~

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-28-23.

7 AGE — Years — Months — Days — If LESS than 1 day, 2 hrs. or 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt
(State or country)

PARENTS

10 NAME OF FATHER Harry Basket ville

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.J.

12 MAIDEN NAME OF MOTHER Juanita McThurston

13 BIRTHPLACE OF MOTHER (city or town) Wash DC
(State or country)

14 Informant
(Address) Robert F. Harrison.

Filed 5/29 19 23 Burial Permit No. 9121 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-28 1923

17 I HEREBY CERTIFY, That I attended deceased from 5-28, 1923, to 5-28, 1923.

that I last saw her alive on 5-28, 1923

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Premature with congenital deformity.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY
(Secondary) ...
(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Susanne R Causey M. D.

(Address) 1702 Westwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

JOHNS HOPKINS HOSPITAL

20 UNDERTAKER ... ADDRESS ... 19

Commissioner Health

MAY 8 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D76201

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D76201

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 Rockwood Ave ST. 27 WARD)

2-FULL NAME Baby McDade (Un named. (7 hrs Old))

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. ..... St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 26 (Day), 1923 (Year)

7-AGE, Few hours ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, 10 hrs. or ..... mn.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Bernard McDade

11-BIRTHPLACE OF FATHER (State or Country), Scotland

12-MAIDEN NAME OF MOTHER Jennie McCabe

13-BIRTHPLACE OF MOTHER (State or Country), Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- [illegible] Harrison JOHNS HOPKINS HOSPITAL

MAY 29 1923 Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 27 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 26 1923, to May 27 1923, that I saw h[illegible] alive on May 26 1923, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth (7 hrs)

10 hours (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Congenital weakness

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. J. Turner M. D.

5-27-, 1923 (Address) 5716 North Ave Balto

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, ...

DATE OF BURIAL, ..., 191...

20-UNDERTAKER .....

ADDRESS .....

MAY 28 1923

Commissioner Health.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 29 1923

168

0419

Spec.—6-9-19—H. P. Co.—1000 Blks.

D76202 HEALTH DEPARTMENT—CITY OF BALTIMORE D76202

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. St. Elizabeths Home ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edmond Burke

(a) RESIDENCE. NO. St. Elizabeths Home ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 16/22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Foundling (Balto. Md.)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Foundling

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant

(Address)

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1923

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1923, to May 27, 1923, that I last saw him alive on May 27, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Tuberculosis (see note in book)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Boyd, M. D.

May 27, 1923 (Address) 2005 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19

20 UNDERTAKER

ADDRESS

Commissioner of Health

MAY 29 1923

BY 291823

Burial Permit Clerk

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death may be stated. PHYSICIANS should state TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Imported this case as Bronchopneumonia but further developments & physical findings make me believe that the Pneumonia was of Tuberculous origin and hence the case should be listed under "Infantile Pulmonary Tuberculosis"

J. J. Ayd

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76203

CERTIFICATE OF DEATH.

X74-502 D76203

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital (St., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Humphrey

(a) RESIDENCE NO. Stoney Run, (St.) ..... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

(c) Name of employer: Mr. Rae Stoney Run Md.

9 BIRTHPLACE (city or town) (State or country): Balto Co, Md.

PARENTS

10 NAME OF FATHER: George Humphrey

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: Sarah Jacobs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant: Hospital Records
(Address)

15 Filed ..... 19 ..... Registrar
Robert P. Garrison,

5 29 1923

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 19, 1923.

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1923, to May 19, 1923.
that I last saw him alive on May 19, 1923,
and that death occurred, on the date stated above, at 6.50 P. m.
The CAUSE OF DEATH* was as follows:

Cerebral Embolism.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Gangrenous foot

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs.

(Signed) B. M. Rhodes M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: 19 MAY 29 1923

20 UNDERTAKER

ADDRESS

Commissioner Health.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76204

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D76204

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 W Redwood ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Teberis

(a) RESIDENCE No. 603 W Redwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 28. 1922

7 AGE 1 Years 1 Months 1 Days If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) No

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Teberis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Mary Matukitis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant Joseph Teberis

(Address) 603 W Redwood Street

15 MAY 29 1923 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28. 1923

17 I HEREBY CERTIFY, That I attended deceased from May, 15, 1923, to May, 28, 1923, that I last saw him alive on May, 28, 1923, and that death occurred, on the date stated above, at 10. P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) - yrs. - mos 21 ds.

CONTRIBUTORY (Secondary) Retro pharyngeal abscess

Cervical adenitis (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Consultation

(Signed) Dan Franklin M. D.

5/29. 1923 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 30. 1923

20 UNDERTAKER ADDRESS

John Grebliauckas J.G. 425 S Paca St

Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN about state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76205

CERTIFICATE OF DEATH.

D76205

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 3895 Arlington St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Bahner

(a) Residence No. 3895 Arlington St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Late Katherine Bahner

6-DATE OF BIRTH (month, day and year) Sept 12 1848

7-AGE. 75 yrs. 8 mos. 16 ds. If LESS than 1 day, ...hrs. or ...min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Tanner

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Nicholas Bahner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Kat Rowe

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Elizabeth Lunz

(Address) 3885 Arlington st

15- Filed ... 19... Robert P. Harrison, Registrar.

MAY 29 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 28-23

17- I HEREBY CERTIFY, That I attended deceased from May 24th 1923 to May 28 1923.

that I last saw him alive on May 28 1923 and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchopneumonia Septicemia

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uremia 3

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? Centerville

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. Schroeder M. D.

May 28, 1923 (Address) 3301 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem

DATE OF BURIAL: May 30 1923

20-UNDERTAKER: Thos. J. Miller

ADDRESS: 2334 Jefferson

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76206 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76206

CERTIFICATE OF DEATH. X 201

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltr. City Jail St., 10 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo. W. Baker

(Residence in Baltimore: No. (Deer Lodge Boat) St.; yrs., mos., ds.)

Insurances in Balto

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced. (Write the word.): Divd twice

6-DATE OF BIRTH: ..... 1..... (Month) (Day) (Year)

7-AGE: 0 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Sailor
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER: [illegible]

11-BIRTHPLACE OF FATHER, (State or Country):

12-MAIDEN NAME OF MOTHER:

13-BIRTHPLACE OF MOTHER, (State or Country):

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address)

15-

Filed MAY 29 1923 192

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MAY 29 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 22 192 3 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy and inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

(1) Fractured skull

Cause of injury to this July 1st (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneum. in skull due to injury & exhaustion (Duration) yrs. mos. ds.

(Signed) W. Reilly M. D.

(Coroner)

May 23 192 3 (Address) 1632 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death 12 hours yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: PUBLIC CEMETERY.

DATE OF BURIAL: 192

20-UNDERTAKER: Commissioner Health

ADDRESS MAY 29 1923

MAY 29 1923

B

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

163978
D76207

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 57 D76207

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W. Rush. S.C.

(a) RESIDENCE NO. 137 N. Main St. Greenwood ST., WARD Greenwood S. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or Wife)~~ Eppie Rush

6 DATE OF BIRTH (month, day, and year) Sept 6-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	48	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C

PARENTS

10 NAME OF FATHER William Rush

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C

12 MAIDEN NAME OF MOTHER Sarah E. Rush

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C

14 Informant Benjamin F. Rush
(Address) Greenville S. C.

15 Filed 29 1923 . 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1923

17 I HEREBY CERTIFY, That I attended deceased from April 17. 1923. to May 29. 1923.
that I last saw him alive on May 29. 1923.
and that death occurred, on the date stated above, at 10 45 a m.
The CAUSE OF DEATH* was as follows:

Diabetes mellitus.

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis (Hemorrhage central.) (duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of May 26, 23.

Was there an autopsy? No

What test confirmed diagnosis? Chemical tests.

(Signed) R Steenman, M. D.

May 29. 1923 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenwood. S. C. DATE OF BURIAL 5/29/23

20 UNDERTAKER H E Stokes ADDRESS 424 N Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76208 — 129 — D76208

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1519 Eastern ave St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Anna Weiss Anna Weiss

(a) Residence No. 1519 Eastern ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): X

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank was

6-DATE OF BIRTH (month, day and year): July 4 1861

7-AGE. 61 yrs. 10 mos. 24 ds. If LESS than 1 day ...hrs. or ...min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Poland

PARENTS.

10-NAME OF FATHER: Andrew Kwiatkowski

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14- (Informant) Frank was
(Address) 1519 Eastern ave

15- 19... Registrar.
Robert P. Harrison
Burial Permit Clerk

MAY 29 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 28/23

17- I HEREBY CERTIFY, That I attended deceased from April 15 1923 to May 28 1923
that I last saw h... alive on ... 19...
and that death occurred, on the date stated above, at 7 A M
The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) ... yrs. ...

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr H Jaumpe Phy MD
, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: May 30, 1923

20-UNDERTAKER: John M Weber — ADDRESS: 803 Bank St

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Blks.

D76209

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76209

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 Bareley ST., 12 WARD)

2-FULL NAME Fannie V. Foose

(a) RESIDENCE NO. 1714 Bareley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Sept. --, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	75	8	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond
(State or country) Virginia

PARENTS

10 NAME OF FATHER Samuel Foose

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Anne Burton

13 BIRTHPLACE OF MOTHER (city or town) Richmond
(State or country) Virginia

14 Informant Mrs. Grace E. Harrington
(Address) 1532 Park Avenue

15 Filed May 29 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1923

17

I HEREBY CERTIFY, That I attended deceased from June 10, 1922, to May 27, 1923,

that I last saw h[illegible] alive on May 26, 1923,

and that death occurred, on the date stated above, at 12.30 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis - bed ridden for almost 1 year from dislocated ankle (duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Ralph Josephs, M. D.

(Address) 4245 North Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	5/30 1923
20 UNDERTAKER	**ADDRESS**
Henry W. Mears & Son	805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D76210

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 William ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora May Schoon

(a) RESIDENCE NO. 1114 William ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) April 7 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) Rock Hall (State or country) Kent Co. Md.

PARENTS

10 NAME OF FATHER George A. Schoon

11 BIRTHPLACE OF FATHER (city or town) Rock Hall (State or country) Kent Co. Md.

12 MAIDEN NAME OF MOTHER Annie H. Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant George A. Schoon (Father) (Address) 632 Harvey St.

15 Robert P. Harrison, 19

Burial Permit Clerk. Registrar

Y 29 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1918 to May 28. 1923.

that I last saw h[illegible] alive on May 26, 1923,

and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

probably (duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? dont know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) Martin F. Hoan M. D.

5.29. 1923 (Address) 414 Prof. Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rock Hall Md. via Md. Del & Va. R.R.

DATE OF BURIAL May 30 1923

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76211 101-001 D76211

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 21 Edgewood Ave ST., Gardenville (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Winkler

(a) RESIDENCE No. 21 Edgewood ave. ST., Gardenville WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): March 13th 1921

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
1	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Chas. W. Winkler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Mayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Maryland

14 Informant: Charles W. Winkler (Address) 218 Glenwood Ave Govanstown

15 May 29 1923 Robert P. Harrison, Registrar

Deputy Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1923

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1923, to May 28, 1923, that I last saw her alive on May 27 - 1923, and that death occurred, on the date stated above, at 4:15 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

7 days (duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Henry D. Corse M. D.

, 19 (Address) Gardenville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 30, 23
20 UNDERTAKER	ADDRESS
Fred'k Loeschner Sons	Fullerton

GE should be stated EXACTLY. PHYSICIA... sho... state
at it may be properly classified. Exact statement of o... UPA-
TION is very important. See instructions on back of certificates.

Spec.—3-10-21—M&T—1500 Bks.

D76212

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X60-001 D76212

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

2-FULL NAME Anna Dair

(a) RESIDENCE NO. Midland Ave ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Dair

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Hospital Records

15 FILED MAY 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1923, to May 29, 1923, that I last saw her alive on May 29, 1923, and that death occurred, on the date stated above, at 6.55 P. m.

The CAUSE OF DEATH* was as follows:

Graves Disease
(Exophthalmic Goitre)

(duration) ..... yrs. 6 mos ? ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas. W. Cumming M.D., M. D.

, 19 (Address) J. H. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Md Cand Md — DATE OF BURIAL June 1 1923

UNDERTAKER John J. Leonard & Son — ADDRESS 901 Madison Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76218

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76218

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 634 (St.) Smith (Ward) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Indiana Gray

(a) RESIDENCE. No. 634 Smith St. ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year): 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
57		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: William Dipm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Rebecca Horsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Anita Burgs

(Address) 634 Smith St.

MAY 29 1923. 19 Date Received

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-27-1923

17

I HEREBY CERTIFY, That I attended deceased from May 27th, 1923, to —, 19—, that I last saw her alive on May 27th, 1923, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis (Direct)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Palpation & Auscultation

(Signed) Jas C Burgin, M. D.

. 19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion	May 30 1923
20 UNDERTAKER	ADDRESS
Evans Funeral Home	114 W

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Blks.

D76214

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76214

CERTIFICATE OF DEATH.

74-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1631 Westwood ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Hellwig

(a) RESIDENCE No. 1631 Westwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Hellwig

6 DATE OF BIRTH (month, day, and year) July 21 46

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	76	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm L Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Robert H Hellwig

(Address) 1631 Westwood

15 Filed MAY 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1923, to May 27, 1923.

that I last saw her alive on May 26, 1923.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Embolism of Lung

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) yrs. mos 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Fred Talbot, M. D.

, 19 (Address) 1353d North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elkridge Md — DATE OF BURIAL May 30 1923

20 UNDERTAKER W M Routson — ADDRESS 2238 N Mott

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied.

Spec—12-23-21—L.B.R.S.—400 Blks.

D76215

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76215

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Little Sisters of the Poor, St., 10, Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie Vandeventer

(a) Residence No. Preston & Valley Sts St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single, Married,~~ Widow Widowed, ~~or Divorced,~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Vandeventer

6-DATE OF BIRTH (month, day and year) Oct. 11th 1844

7-AGE. 78 yrs. 7 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Norfolk Va.

PARENTS

10-NAME OF FATHER, Robert Pettit

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Susan A. Moore

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

11- (Informant) Sister Florence

(Address) Preston & Valley

15- Filed MAY 30 1923 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 29 1923

17- I HEREBY CERTIFY, That I attended deceased from No record 19..... to 19.....

that I last saw h Sr alive on May 27 1923

and that death occurred, on the date stated above, at 8.30 m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. A. Bowen M. D

29 1923 (Address) 1833 Valley st

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Norfolk Va	May 30 1923
20-UNDERTAKER. H. Sander Sons	ADDRESS 1710 Pearl St.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76216 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76216

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 1701 Frederick ave St., 11 Ward) Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wilhelm Walter Hirschner

(Residence in Baltimore: No. 104 W Eager St St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word): Married

6-DATE OF BIRTH: May (Month) 26 (Day) 1873 (Year)

7-AGE: 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): apt House

9-BIRTHPLACE, (State or Country): Balto

PARENTS.

10-NAME OF FATHER: Louis Hirschner

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Dorothea Kiess

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Hirschner

(Address) 712 Haw St

15- Filed MAY 30 1923 192.. ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: May (Month) 27 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic nephritis,
Interstitial

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart (Duration) Sudden yrs. mos. ds.

(Signed) Jno. M. Fowlkes M. D. (Coroner)

May 28 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Western — DATE OF BURIAL: May 30 19..

20-UNDERTAKER: Stouffer & Son — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76217

CERTIFICATE OF DEATH.

162 D76217

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3246 Colgate St ST., N WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Worrell

(a) RESIDENCE NO. 3246 Colgate St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City (State or country)

PARENTS

10 NAME OF FATHER Harrison Worrell

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Mazie Fealey

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Co. (State or country)

14 Informant Harrison Worrell (Address) 3246 Colgate St.

15 MAY 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1923

17

I HEREBY CERTIFY, That I attended deceased from May 29, 1923, to May 29, 1923, that I last saw him alive on May 29, 1923, and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. 15 min ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) J. W. Sakenheim M. D.

May 29 1923 (Address) 3730 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 5/30 1923

20 UNDERTAKER Philip Henry — ADDRESS 2016 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76218 ✓ 75-001 D76218

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Woodward

(a) RESIDENCE NO. Bay View Asylum. 927 Leadenhall. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anne Arundal Co., Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records.

(Address)

15 Filed MAY 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1923

17

I HEREBY CERTIFY, That I attended deceased from November 25 1919 to May 27 1923.

that I last saw her alive on May 27 1923.

and that death occurred, on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Hypertension

Left Hemiplegia (Residual)

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McPowell, M. D.

5-29-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	May 30, 23
20 UNDERTAKER John H. Frazier	ADDRESS 192 Uniform St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76219

CERTIFICATE OF DEATH.

100-001 D76219

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Smith

(a) RESIDENCE NO. 817 Pebble Court. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or....min.
76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown? (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Unknown

14 Informant Municipal Hospital Records.
(Address)

15 Filed MAY 30 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1923, to May 28, 1923, that I last saw h.. alive on May 28, 1923, and that death occurred, on the date stated above, at 7:20 P. M.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McPowell, M. D.

5-29 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL June 1 1923

20 UNDERTAKER John H. Soader

ADDRESS 142 Walbrook St

AGE should be carefully supplied. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76220

CERTIFICATE OF DEATH.

49

D76220

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 West 25th ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Henry Cairnes

(a) RESIDENCE NO. 21 West 25th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If ~~married~~, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of 6. Virginia Cairnes

6 DATE OF BIRTH (month, day, and year) May 1st 1838

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	85		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Darrettsville, Harford Co., Md.

PARENTS

10 NAME OF FATHER Isaac H. Cairnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann Watt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant W. R. Swift

(Address) 2039 Madison ave

15 Filed MAY 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1923

17

I HEREBY CERTIFY, That I attended deceased from March 3 1923 to May 28 1923 that I last saw him alive on May 28th 1923 and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Malignant Papilloma of Bladder

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopical Findings

(Signed) William J. Hesselbrock M. D.

, 19 (Address) 1700 Linden ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Delled Cem Harford Co

DATE OF BURIAL May 31st 1923

20 UNDERTAKER Henry W. Jenkins Sons Co

ADDRESS McCulloh & Orchard

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76221

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D76221

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 657 Bradley ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Barnes

(a) RESIDENCE NO. 657 Bradley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Wm H. Barnes

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Clementine Palmer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Wm H. Barnes (Address) 657 Bradley St

15 Filed MAY 30 1923 ROBERT R. KRAUTER, Register Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1923

17

I HEREBY CERTIFY, That I attended deceased from May 15th, 1923, to May 29th, 1923, that I last saw him alive on May 27th, 1923, and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows: Bronchio Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A Lee Ellis, M. D.

5/29, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cem

DATE OF BURIAL 5/31/1923

20 UNDERTAKER Samuel T Kreeger & Bro

ADDRESS 578

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AGE should be carefully supplied.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

]Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary.
(

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76222

CERTIFICATE OF DEATH.

D76222 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1113 Mosher ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Sneacl

(a) RESIDENCE. NO. 1113 Mosher ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 16 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 29, 1922

7 AGE: Years 1 Months 4 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Oscar Sneed

11 BIRTHPLACE OF FATHER (city or town) Fayetteville
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Hannah Smith

13 BIRTHPLACE OF MOTHER (city or town) Larkinburg
(State or country) Virginia

14 Informant Oscar Sneed
(Address) 1113 Mosher St

15 Filed MAY 30 1923 ROBERT R. KRAMER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1923

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1923, to May 29, 1923, that I last saw him alive on May 29, 1923, and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Pertussis Convulsis

(duration) yrs. mos. 2 1 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos Two ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) John E. G. Lampi M. D.

19 (Address) 1400 N. Mount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: May 30 1923

20 UNDERTAKER: Samuel Hensley ADDRESS: 78 N Bridle

REGISTRAR should be careful to supply. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Winfree

D76223 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 74-001 D76223

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 948 Tyson St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Agnes Winfrey 35

(Residence in Baltimore: No. 948 Tyson St. St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female | 4-COLOR OR RACE: colored | 5-Single, Married, Widowed, or Divorced, (Write the word.): widow

6-DATE OF BIRTH. about 1878
(Month) (Day) (Year)

7-AGE. 53 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Launder
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Warren Winfree

(Address) 1220 W. 70th St. Balto. Md.

15- MAY 30 1923 192 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 28 1923
(Month) (Day) (Year)

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) No history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

May 30 1923 (Address) 2.80 E. Lexington St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Laurel Cem. DATE OF BURIAL. 5/31/1923

20-UNDERTAKER. Samuel Hemsley ADDRESS N. Bedford ✓ 78

If Dead

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-19-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76224

CERTIFICATE OF DEATH.

X 4 4 D76224

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

2-FULL NAME Mary Timmons

(a) RESIDENCE NO. ..... ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John E. Timmons

6 DATE OF BIRTH (month, day, and year): June 8 1848

7 AGE — Years: 74 — Months: 11 — Days: 21 — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: house wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: William Littlefield

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Shoemaker

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Mattie J. Timmons

(Address): Magnolia Md

15 MAY 30 1923 ROBERT R. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 29 1923

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1923, to May 29, 1923,

that I last saw h[illegible] alive on May 29, 1923,

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) 1 yrs. mos da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death? ..... Home

Did an operation precede death? Yes Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James H. Adelbrson M. D.

19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Md Mountain Cemetery — DATE OF BURIAL: June 1 1923

20 UNDERTAKER: Howard K McComas — ADDRESS: Abingdon Md

MAGE should be carefully supplied. AGE. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76225 HEALTH DEPARTMENT—CITY OF BALTIMORE D76225

CERTIFICATE OF DEATH. 100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 403 N. Stricker ST. 19 WARD)

2-FULL NAME Frances [illegible] Luciana

(a) RESIDENCE NO. 403 N. Stricker ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 19 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Luciana

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Carletti

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Joseph Luciana (Address) 403 N. Stricker St

15 Filed MAY 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1923

17 I HEREBY CERTIFY, That I attended deceased from April [illegible], 1923 to May 29, 1923, that I last saw him alive on May 28, 1923, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? At place

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) J. Shulert Lowe, M. D.

5/29 1923 (Address) 1901 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL May 31 1923

20 UNDERTAKER John Zucrist

ADDRESS 2008 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D76226

CERTIFICATE OF DEATH.

D76226

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

t-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 N. Fulton Ave ST. 15 WARD)

2-FULL NAME Mary Louise Conser

(a) RESIDENCE. No. 1424 N. Fulton Ave ST., WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Corthan C. Conser

6 DATE OF BIRTH (month, day, and year) Oct 7. 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	7	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS
t0 NAME OF FATHER Louis Troller
t1 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
t2 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Dr Chas. C. Conser
(Address) 1101 N. Fulton Ave.

15 Filed MAY 30 1923 ROBERT R. KRAMER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1923

t7 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to May 28, 1923, that I last saw h[illegible] alive on May 27, 1923, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Chron. Endocarditis

Unknown — mos. — ds.
(duration) yrs.

CONTRIBUTORY (Secondary) Anasarca
(duration) — yrs. 5 mos. — ds.

t8 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas C. Conser M. D.
5/29 1923 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leadenhall	May 31 1923
20 UNDERTAKER	ADDRESS
William Cook	502 E Natha

t-IMPORTANT.—THIS IS A PERMANENT RECORD. Every item of this information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D76227 D76227

CERTIFICATE OF DEATH. 129

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 19 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm McGinnis

(Residence in Baltimore; No. 1400 McHenry St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: May (Month) 7 (Day) 1870 (Year)

7-AGE: 53 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): Manufacturing

9-BIRTHPLACE (State or Country): Md

PARENTS

10-NAME OF FATHER: Dont Know

11-BIRTHPLACE OF FATHER (State or Country): B.

12-MAIDEN NAME OF MOTHER: Hanna McGinnis

13-BIRTHPLACE OF MOTHER (State or Country): B

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ewd McGinnis

(Address) 1400 McHenry St

15-FILED MAY 30 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: May (Month) 29th (Day) 23 (Year) 192..

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Nephritis

uremia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H H Kelly M. D.

(Coroner.)

May 30 1923 (Address) 1659 Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death: Few hours yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Woodlawn	May 31 1923

20-UNDERTAKER: John Fields ADDRESS 1500 W Fayette

(1) Enter CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D76228 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

43 D76228

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 W. Saratoga ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertram E. King

(a) RESIDENCE NO. 600 W. Saratoga St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 10-1880.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk. 9

(b) General nature of industry, business, or establishment in which employed (or employer): market. 60

(c) Name of employer

9 BIRTHPLACE (city or town) Washington (State or country) D. C.

PARENTS

10 NAME OF FATHER Alexander King

11 BIRTHPLACE OF FATHER (city or town) New York (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Emma King

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant: Emma James. (Address) 600 W. Saratoga St.

15 FILED MAY 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1923

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1923, to May 29, 1923, that I last saw him alive on May 25, 1923, and that death occurred, on the date stated above, at 9:45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of mouth, tongue + throat

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? yes Date of June 1st + 15th 1922.

Was there an autopsy? no

What test confirmed diagnosis? microscopical examination

(Signed) Chester Richards, M. D.

5-24, 1923 (Address) 552 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: May 30 1923

20 UNDERTAKER: E. A. Windsfeld Jr — ADDRESS: 501 E 22

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76229

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

D76229

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 307 E 33rd ST. 12 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Gertrude Hardesty

(a) RESIDENCE. No. 307 E 33rd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 7 1905 ~~1904~~

7 AGE. Years	Months	Days	If LESS than 1 day, hrs. or min.
17 ~~18~~	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm Hardesty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somerset Land Md

12 MAIDEN NAME OF MOTHER Lula Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Wm Hardesty (Address) 307 E 33 St

15 Filed MAY 30 1923 . 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29th - 1923

17

I HEREBY CERTIFY, That I attended deceased from May 21st, 1923, to May 29th, 1923, that I last saw h[illegible] alive on May 28, 1923 and that death occurred, on the date stated above, at 2 PM in.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm M Wing M. D.

, 19 (Address) 1801 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	May 31 1923
20 UNDERTAKER	ADDRESS
E A Windsor Jr	501 E 22 St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 2 - 1923

Personally appeared before me this
2nd day of July - 1923. Wm
Wm Hardesty father of Lillian Gertrude
Hardesty who made affadivit that
the date of Birth of this Daughter
Lillian Gertrude Hardesty, should
be Sept 7-1905 instead of
Sept 7-1904. the same should
be 17 yrs. 8 months 22 days

Seal William E. Hardesty
Father

Seal George H. Grese
Notary Public

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76230

CERTIFICATE OF DEATH.

74-001 D76230

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1918 E. 31st ST., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. Wilson

(a) RESIDENCE NO. 1918 E. 31st ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late Capt. L. B. Wilson

6 DATE OF BIRTH (month, day, and year): Jan 3/64

7 AGE — Years: 59 — Months: 4 — Days: 26 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Somerset Co, Deal's Island, Md

PARENTS

10 NAME OF FATHER: John W. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth S. Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Mrs 1918 E. 31st st

15 Filed MAY 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 29 1923

17 I HEREBY CERTIFY, That I attended deceased from March, 1922, to May 29, 1923, that I last saw her alive on May 28, 1923, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Myocarditis

(duration) 1 yrs. 3 mos ds.

CONTRIBUTORY (Secondary): Apoplexia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. H. A. Mayer, M. D.

May 29, 1923 (Address) 2438 Linden Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Deal's Island, Somerset Co. Md — DATE OF BURIAL: 6/30/1923

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002

D76231

REGISTERED NO. D76231

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1918 Cecil Ave (St.) 9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernst Zimmermann

(a) RESIDENCE NO. 1918 Cecil Ave St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., If of foreign birth? 75 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ late Amelia Zimmermann

6 DATE OF BIRTH (month, day, and year) Feb 6 39

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	84	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Custom Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katherine Zimmermann (Address) 1918 Cecil Ave

15 Filed MAY 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1923

17 I HEREBY CERTIFY, That I attended deceased from MAY 28 1923, 19, to MAY 29 1923, 19.

That I last saw h/M alive on MAY 29 1923, 19.

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) X yrs. X mos. X ds.

CONTRIBUTORY (Secondary) Sclerosed Circulatory System Heart Kidneys Senile (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis None

(Signed) O. H. Decker M. D.

(Address) 928 E. NORTH AVE

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore. DATE OF BURIAL 5/31 1923

20 UNDERTAKER Philip Hennig ADDRESS 2016 Orleans

MAY 30 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

163787. HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D76232 CERTIFICATE OF DEATH 31 D76232

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 5 WARD)

2-FULL NAME James Foster.

(a) RESIDENCE NO. 1418 Fairmount Ave. City ST.,

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Diana (mother).

6 DATE OF BIRTH (month, day, and year) Nov. 6, 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Maryland

PARENTS

10 NAME OF FATHER Abie Foster,

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Diana Emrals,

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Johns Hopkins Hospital Records

15 Filed 19 ROBERT R. KRAUTER Burial Permit Clerk. Registrar

301923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1923

17

I HEREBY CERTIFY, That I attended deceased from May 19, 1923, to May 27, 1923, that I last saw him alive on May 26, 1923, and that death occurred, on the date stated above, at 6.00 a m.

The CAUSE OF DEATH* was as follows:

Gen. Miliary Tuberculosis

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary) Tuberculous Meningitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy

(Signed) Horton Casparis, M. D.

19 (Address) Johns Hopkins.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery

DATE OF BURIAL: May 30 1923

20 UNDERTAKER: Joseph. T. Rochester

ADDRESS: 1413 E. Monument St

INSTRUCTIONS: This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76233 D76233

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1631 Druid Hill Ave. WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H Holland.

(Residence in Baltimore: No. 1631 Druid Hill Ave Colo. 43 yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Unknown, 1879 (Month) (Day) (Year)

7-AGE, 43 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Undertaker
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country),

PARENTS.

10-NAME OF FATHER. Augustus Holland

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Mary F. Jones

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs G. H. Holland

(Address) 1631 Druid Hill Ave

15- 304923 ....., 191... Dec 8 RM Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 27, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec. 8, 1913, to May 27, 1923, that I saw h[illegible] alive on May 27, 1923, and that death occurred, on the date stated above, at 5.45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(Duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Nephritis

(Duration) yrs. mos. da.

(Signed) W. J. Cox M. D.

May 28 191... (Address) 516 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park DATE OF BURIAL. May 31, 1923

20-UNDERTAKER J Lewis Hall ADDRESS 1924 McCulloh

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

163894
D76234

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76234

CERTIFICATE OF DEATH.

X 84

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Buechel

(a) RESIDENCE NO. 2000 Barnwell St. Columbia S.C. ST., WARD Columbia S. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Wylie M. Buechel

6 DATE OF BIRTH (month, day, and year) May 16, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	43	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER William Grumley

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Johns Hopkins Hospital
(Address)

15 301923 . 19 RRA. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1923

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1923, to May 29, 1923, that I last saw h[illegible] alive on May 29, 1923, and that death occurred, on the date stated above, at 7 50 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor -- cerebral probably glioma

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) operation shock

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of May 29

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) F. L. Reichert, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Columbia S C — DATE OF BURIAL May 30 1923

20 UNDERTAKER Joseph Gibbons — ADDRESS 221 Cherry

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76235 D76235

CERTIFICATE OF DEATH.

66

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 832 Harford ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robt Crawford

(a) RESIDENCE. NO. 832 Harford ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1886

7 AGE: Years 37; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant: Mary Smith

(Address): 832 Harford Ave

15 Filed: MAY 30 1923, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1923

17 I HEREBY CERTIFY, That I attended deceased from May 27- 9 A.M. 19 , to May 27- 3 P.M. 19 , that I last saw h[illegible] alive on May 27 1923, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows: (Acute Gastritis) Acute gastro enteritis, Lardiganitis, Toxemia and drinking Alcoholic Substances

(duration) yrs. 1 mon. 24 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mon. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gen. Exam.

(Signed) G. Garland Schmidt M. D.

May 30 1923 (Address) 1534 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May 31 1923
20 UNDERTAKER	ADDRESS
Mrs. R. A. Elliott	1727 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Stevens)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 76236

CERTIFICATE OF DEATH.

7 D. 76236

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 Calverton Road ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha E. Stevens

(a) RESIDENCE No. 612 Calverton Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 17 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	1	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Eugene E. Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Bertha Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Eugene E. Stevens

(Address) 612 Calverton Road

15 MAY 31 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 30 1923

17

I HEREBY CERTIFY, That I attended deceased from May 23, 1923, to May 30, 1923, that I last saw her alive on May 30, 1923, and that death occurred, on the date stated above, at 11. P.M.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia & Oedema Lungs (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Obs. Exam.

(Signed) John A. Wharton M. D.

MAY 30 1923 (Address) 1219 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Kings Georges Va	June 1 1923

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. — 1931 — 5000 Blks.

D76237

163747

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D76237

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Witts

(a) RESIDENCE NO. 1070 N. Dallas St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 8, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Witts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Hubbard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Records

15 MAY 31 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1923

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1923 to May 28, 1923, that I last saw him alive on May 28, 1923, and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 12+ ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL May 31 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76238 HEALTH DEPARTMENT—CITY OF BALTIMORE. D76238

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital 48 ST. WARD)

REGISTERED NO. 38

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lowd A Rohr Rose

(a) RESIDENCE NO. Edmondson Ave. Ferguson ST. WARD State

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 ~~Single~~, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not Known

6 DATE OF BIRTH (month, day, and year): ? ? about

7 AGE: Years 58 — Months — — Days — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gardener

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): N Y

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant (Address): Self.

Filed MAY 31 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 29 1923

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1923, to May 29, 1923, that I last saw him alive on May 29, 1923, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis. (Luetic)

Aortitis

Tabes dorsalis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Edward A. Kelly M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: May 31 1923

A UNDERTAKER: Wm Cook

ADDRESS: 502 E Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76239

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D76239

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 504 Bouldin St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Julia Lorraine Taylor.

(a) Residence No. 504 Bouldin St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 3 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 20, 1921

7-AGE, 2 yrs. 3 mos. 10 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). Baltimore
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Francis M Taylor

11-BIRTHPLACE OF FATHER (city or town). Baltimore
(State or Country). Maryland

12-MAIDEN NAME OF MOTHER, Edna D Cutsail

13-BIRTHPLACE OF MOTHER (city or town). Baltimore
(State or Country). Maryland

14-

(Informant) Mrs Francis M. Taylor

(Address) 504 S Bouldin St.

15-

Filed MAY 31 1923 19.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 5-30-1923

17- I HEREBY CERTIFY, That I attended deceased from 5-23-23, 19....., to 5-30-23, 19.....

that I last saw h..... alive on....., 19.....

and that death occurred, on the date stated above, at 12.15 P. m.

The CAUSE OF DEATH* was as follows:

Pneumococcic Peritonitis

(Duration) ..... yrs. ..... ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

Signed ..... M. D.

5-30 19 23 (Address) 2039 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Orem Cemetery

DATE OF BURIAL, May 31, 1923

20-UNDERTAKER, Freeman

ADDRESS 32 O'Donnell

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76240

CERTIFICATE OF DEATH. X 199

D76240

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma H. Jackman

(a) RESIDENCE NO. Jessups Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 17 ds. How long in U. S., if of foreign birth? 20 yrs. 3 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leo. Jackman

6 DATE OF BIRTH (month, day, and year) Feby 22 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	20	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Walter Stopford

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Lulie Marie Prieto

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Walter Stopford (Address) 814 Ave Overlea

15 MAY 31 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 - 1923

17

I HEREBY CERTIFY, That I attended deceased from May 1st, 1923, to May 29, 1923,

that I last saw her alive on May 29, 1923,

and that death occurred, on the date stated above, at 11.55 a m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(over)

(duration) yrs. 8 Wks ds.

CONTRIBUTORY (Secondary) Septic Pneumonia

(duration) ..... yrs. ..... mos. 18 ds.

18 Where was disease contracted if not at place of death? Jessups Md 5th yes

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Jno A Compton M. D.

, 19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	May 31 1923
20 UNDERTAKER	**ADDRESS**
Chas. G. Black	742 W. North ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76241

CERTIFICATE OF DEATH.

D76241

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pronounced dead at University Hospital 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas M. Cruse

(a) RESIDENCE NO. 1602 Guilford Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 11 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Cruse

6 DATE OF BIRTH (month, day, and year) June 5. 1851

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
71	11	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cigar Maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Henry S Cruse

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Isabel Jane Ford

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Chas M Cruse
(Address) 1602 Guilford Ave

15 FILED MAY 31 1923 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

From Uremia Paralysis Heart disease

(duration) yrs. Don't know mos. ds.

CONTRIBUTORY (Secondary) Don't know

(duration) yrs. mos. ds.

(Signed) W R Terrell, M. D. (Coroner.)

5. 30. 1923 (Address) 111 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL June 1st 1923

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 E Monument St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D76242 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D76242

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secour Sisters Hospl 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARY JOSEPH NORMAN.

(a) RESIDENCE No. 10-E-Mulberry-Street. ST., 4 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? 60 yrs. 7 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year) October-9-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	60	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER John Norman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Ireland

12 MAIDEN NAME OF MOTHER Margaret Byrne

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown Irland

14 Informant Mr. Hugh A. Norman (brother)
(Address) 1508-W-Fayette-St., City

15 MAY 31 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1923

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1923, to May 29, 1923, that I last saw h[illegible] alive on May 29, 1923, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriolo Sclerosis
chronic pulmonic

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 10 E Mulberry

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Edward Nevelacer M. D.

, 19 (Address) 24 W Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: June-1-23

20 UNDERTAKER: STEWART & MOWEN COMPANY
[illegible] F. WOOD[illegible], Secretary

ADDRESS: 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Richard Harry Hofstetter)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76243

CERTIFICATE OF DEATH.

D76243

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Harford Ave. St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Harry Hofstetter

(a) RESIDENCE NO. Harford Ave. ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Hofstetter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lucinda Stuart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Charles E. Hofstetter
(Address) Harford Road & Fifth ave.

15 Filed MAY 31 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1923

17 I HEREBY CERTIFY, That I attended deceased from May 23 1923 to May 30 1923.

that I last saw him alive on May 30 1923.

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. Frances M. D.

5/31 1923 (Address) 1407 N. Guy St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 1 '23
20 UNDERTAKER	ADDRESS
Fred Lassahn & Son	Fulton

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Brendel)

D76244 HEALTH DEPARTMENT—CITY OF BALTIMORE D76244

57

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Brendle

(a) RESIDENCE NO. 127 N. Carey ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam Brendel

6 DATE OF BIRTH (month, day, and year) Oct 10

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	66	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Brendel (Address) 1624 Eastlake

15 MAY 31 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-27-1923

17 I HEREBY CERTIFY, That I attended deceased from 3-25-, 19--, to 5-27-, 19--,

that I last saw h-- alive on 5-27-, 19--,

and that death occurred, on the date stated above, at 1:00 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage of Lungs

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? In Canada

Did an operation precede death? Date of 3-25-23

Was there an autopsy? No

What test confirmed diagnosis? Lab. findings

(Signed) [illegible], M. D.

5-27, 19-- (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL June 1 1923

20 UNDERTAKER Wendell Bryfogle & Son — ADDRESS 878 Penna

NOTICE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76245

CERTIFICATE OF DEATH.

D76245

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 N Glover ST.; 6 WARD) 161-601

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME No Name

(Residence in Baltimore: No. 427 N. Glover St St.; ....yrs.. ....mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOW OR DIVORCED. (*Write* the word.): Single

6-DATE OF BIRTH, May (Month) 30 (Day), 1923 (Year)

7-AGE, ...yrs....mos....ds. If LESS than 1 day, ...hrs. or 15 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), 427 N Glover St

PARENTS.

10-NAME OF FATHER, Israel Finnerty

11-BIRTHPLACE OF FATHER (State or Country), City

12-MAIDEN NAME OF MOTHER Marie Cutter

13-BIRTHPLACE OF MOTHER (State or Country), City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Israel Finnerty

(Address) 427 N. Glover St

15- Filed MAY 31 1923 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 30 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 30 1923, to May 30 1923, that I saw h[illegible] alive on May 30th 1923, and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Premature - Birth

5 mos. (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos. N. Magruder M. D.

5/31, 1923 (Address) 14 East Read St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid | DATE OF BURIAL, May 31., 1923

20-UNDERTAKER Randall Wyffel & Son | ADDRESS 378 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76246 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 7/4-001 6246

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2204 Garrison Ave (or) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna Buffington

(a) RESIDENCE. NO. 2204 Garrison ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	N.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Buffington

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll County Maryland

PARENTS

10 NAME OF FATHER John White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant (Address) John J Buffington Light & Lombard sts

15 MAY 31 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 27, 1923, to May 29, 1923, that I last saw h[illegible] alive on May 29, 1923, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia: Lues & Bulbar Paralysis. Infl. and rd. Cases. Both. successively

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage. Respiratory Paralysis (duration) — yrs. — mos. 1 hr.

Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Gen. Clinical.

(Signed) Wesley Cole, M. D.

5/30, 1923 (Address) 2202 Garrison st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	June 1 1923
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-2t—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76247

CERTIFICATE OF DEATH.

155 D76247

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Page Jr.

(a) RESIDENCE No. 2505 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 19, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		14	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Edward L. Page

11 BIRTHPLACE OF FATHER (city or town) Mary-land (State or country)

12 MAIDEN NAME OF MOTHER Helen Shantley

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Father Edward Page

(Address) 2505 N Calvert st

15 Filed MAY 31 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1923

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1923, to May 31st, 1923, that I last saw h[illegible] alive on May 31st, 1923, and that death occurred, on the date stated above, at 5.45 9m.

The CAUSE OF DEATH* was as follows:

Acute mastoiditis

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Septic meningitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of May 19-23

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: June 2 1923

20 UNDERTAKER: Geo J Smith — ADDRESS 1532 Hollins st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76248

CERTIFICATE OF DEATH.

129 ✓ D76248

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2919 Windsor Ave. ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles C. Steinbach.

(a) RESIDENCE NO. 2919 Windsor Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary S. Steinbach.

6 DATE OF BIRTH (month, day, and year) January 2nd. 1862.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	61	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Harness maker.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Christopher Steinbach.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Amelia Macher.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mary S. Steinbach. (wife)

(Address) 2919 Windsor Ave.

15 Filed MAY 31 1923 19 EG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29th. 19 23.

17

I HEREBY CERTIFY, That I attended deceased from March 9th. 1928 to May 29th. 1928.

that I last saw him alive on May 28th. 1928.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ----------

Did an operation precede death? No. Date of ------

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Signed) Otto M. Reinhardt, M. D.

5/30 19 23 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery.

DATE OF BURIAL: May 31 1923

20 UNDERTAKER: John F. Denny

ADDRESS: 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76249

CERTIFICATE OF DEATH.

114 D76249

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 2321 Pennsylvania St.; 14 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Barbara Brown

(Residence in Baltimore: No. 2321 Pennsylvania ave, St.; 71 yrs., .. mos. .. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Female	Colored	Widow

6-DATE OF BIRTH, ... Nov. (Month) 15 (Day), 1851 (Year)

7-AGE, 75 yrs. 6 mos. 14 da. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Hamsher

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Barbara

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Mary Gonce

(Address) 2321 Pennsylvania ave

15- MAY 31 1923

Filed ..... 19..., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 29, 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16 1923, to May 29 1923, that I saw h[illegible] alive on May 29 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Colitis

(Duration) 3 yrs. .... mos. .... da.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) .... yrs. .... mos. .... da.

(Signed) Wm E Lee M. D.

May 30, 1923 (Address) 856 W. Fort ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cath. Cem DATE OF BURIAL, June 1, 1923

20-UNDERTAKER Jos. J. Kerr ADDRESS 156 N. Eutaw

N. B.—Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76250

CERTIFICATE OF DEATH.

129 D76250

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1802 W Fayette ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Strazskiewicz

(a) RESIDENCE NO. 1802 W. Fayette ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male — 4 COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced: ~~HUSBAND of~~ ~~(or) WIFE of~~ Minna H. Strazskiewicz

6 DATE OF BIRTH (month, day, and year) Feb 16 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	73	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer): Ret'd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Just Strazskiewicz (Address): 1802 W Fayette St

15 Filed MAY 31 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-29 1923

17

I HEREBY CERTIFY, That I attended deceased from May 23, 1923, to May 28, 1923.

That I last saw her alive on May 28, 1923, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Cedema of Lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Walter A Coe, M. D.

5/29, 1923 (Address) 64 E Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westen Cem — DATE OF BURIAL: 5/31/23

20 UNDERTAKER: Geo. F. Talley Fulton — ADDRESS: W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back, of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D76251

CERTIFICATE OF DEATH.

89 D76251

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1915 W Lombard St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph M. Neumann

(Residence in Baltimore: No. 16 S. Hilton St.; yrs. 57 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. 1866
(Month) (Day) (Year)

7-AGE. 57 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Brick worker
(b) General nature of industry, business, or establishment in which employed (or employer). Brick factory

9-BIRTHPLACE, (State or Country). Balto Co

PARENTS.

10-NAME OF FATHER. Adam Neumann

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Cecelia Roemer

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Neumann

(Address) 27 Fenelon Ave

15-

Filed ..... 192.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 29 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Angina Pectoris

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Rupture of Coronary Artery

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) James M Fenton M. D.
(Coroner.)

192 ... (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Cath Cem

DATE OF BURIAL. 6/1/23

20-UNDERTAKER. Fw A Tuley

ADDRESS Fulton & Fayette

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76252

CERTIFICATE OF DEATH.

9 ✓ D76252

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 257 West 31st St.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Clement Reindollar

(Residence in Baltimore: No. 257 W. 31st St.; ....yrs., ...mos. ....ds.)

CAUSE should be stated EXACTLY. PHYSICIANS should state important. See instructions on back of certificate. AGE should be stated in years, months and days. Exact statement of OCCUPATION is very properly classified.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~, ~~WIDOWED~~, OR DIVORCED (Write the word.)

6-DATE OF BIRTH, Aug 29, 1922 (Month) (Day) (Year)

7-AGE, ...yrs. 9 mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ✓
(b) General nature of industry, business, or establishment in which employed (or employer) ✓

9-BIRTHPLACE, (State or Country), and

PARENTS.

10-NAME OF FATHER, Eugene Reindollar and

11-BIRTHPLACE OF FATHER (State or Country), and

12-MAIDEN NAME OF MOTHER, Katie Hines and

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katie Reindollar

(Address) 257 W 31 St

15- Filed MAY 3 1923 191.... GG Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 29, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 28 1923, to May 29 1923, that I saw h[illegible] alive on May 29 1923, and that death occurred, on the date stated above, at 9:58 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

.....

.....

..... (Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Whooping Cough

..... (Duration) ....yrs. 2 mos. 7 ds.

(Signed) Howard Williams M. D.

May 29, 1923 (Address) 254 Herring Run

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. 9 mos. ....ds. In the State ....yrs. 9 mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden — DATE OF BURIAL, May 31, 1923

20-UNDERTAKER, Chenowith & Son — ADDRESS Calvert St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76253

CERTIFICATE OF DEATH.

160 D76253

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2827 Fox ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Jordan

(Residence in Baltimore: No. 2827 Fox St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, May 29, 1923 (Month) (Day) (Year)

7-AGE, ...yrs...mos...ds. If LESS than 1 day, ...hrs. or...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John H Jordan

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Murray

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm H Jordan

(Address) 2729 Fox St.

15- Filed MAY 31 1923, 191... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 29th, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29 1923, to May 29 1923, that I saw h[er] alive on May 29 1923, and that death occurred, on the date stated above, at 5. P.M.

The CAUSE OF DEATH* was as follows:

Congenital Malformation

17hrs.

(Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs...mos...ds.

(Signed) R. S. Townsend M. D.

5-31-23, 1923. (Address) 3543 Chestnut Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Marys Hampden — DATE OF BURIAL, May 31, 1923

20-UNDERTAKER — ADDRESS

GEO. NOWELL & SON, 2017 CHESTNUT AVE.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76254

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76254

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2926 Manchester ST.: 16 WARD)

2-FULL NAME Beauregard Dobson

(a) RESIDENCE. No. 2926 Manchester ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

NOTICE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice E Dobson

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER J Dobson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Blueveins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs Alice E Dobson

(Address) 2926 Winchester

15 Filed MAY 31 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29th 1923

17

I HEREBY CERTIFY, That I attended deceased from May 11th, 1923, to May 29, 1923, that I last saw h im alive on May 28th, 1923, and that death occurred, on the date stated above, at 7.40 a.m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Xray Physical Exam.

(Signed) Wash E Brewington, M. D.

, 19 (Address) 1013 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: June 1923

20 UNDERTAKER: W M Routson — ADDRESS 2238 W North.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76255 D76255

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE, (No. 2419 W. Northern st., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John McCunnings

(a) Residence No. 2419 W. North ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice E Dobson

6-DATE OF BIRTH (month, day and year): July 3 61

7-AGE: 61 yrs. 10 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Carpenter

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS

10-NAME OF FATHER: John McCunnings

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Mason

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Ireland

14-

(Informant): Mrs M J Millen

(Address): 2419 W North ave

15-

Filed MAY 31 1923 Gey Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 29/23

17- I HEREBY CERTIFY, That I attended deceased from Mar 1 1923 to May 29 1923

that I last saw him alive on May 29 1923

and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(Duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Hemorhage

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R. C. Metcalf M. D

May 30 1923 (Address) 1903 W. North ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	June 1 1923
20-UNDERTAKER	ADDRESS
H M Routson	2238 N Mth

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.P.R.S.—400 Bks.

D76256 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D76256

CERTIFICATE OF DEATH.

90 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2412 McElderry St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Price Ryan

(a) Residence No. 2412 McElderry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Barbara E Ryan

6-DATE OF BIRTH (month, day and year): 9 February 1868

7-AGE: 58 yrs. 3 mos. 19 dls. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Shirt operator

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Superintendent

9-BIRTHPLACE (city or town) (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: James Ryan

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: Alice Ryan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14-

(Informant): Barbara Ryan

(Address): 2412 McElderry St

15-

MAY 31 1923 192 ROBERT C. CRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 28-23

17- I HEREBY CERTIFY, That I attended deceased from May 1 1923 to May 28 1923

that I last saw h[illegible] alive on May 28 1923

and that death occurred, on the date stated above, at 1150 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Chronic Interstitial Myocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Pending

(Signed) Fred Rupich M. D

5-29, 1923 (Address) 600 N Patterson Park Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: May 31 1923

20-UNDERTAKER: Louis C. Miller

ADDRESS: 2337 Jefferson

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76257 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76257

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 Orchard ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet E. Johnson

(a) RESIDENCE NO. 5-7 Orchard ST., WARD

(Usual place of shode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob E. Johnson

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
59	(1864)	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Morris Robinson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Jamia Stewart

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Chas E. Johnson
(Address) 529 Orchard St.

15 Filed MAY 31 1923 . 19 Registrar E A S

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/28 1923

17 I HEREBY CERTIFY, That I attended deceased from 5/20 . 1923 . to 5/28 . 1923 .

that I last saw h E alive on 5/27 . 1923 .

and that death occurred, on the date stated above, at 1400 m.

The CAUSE OF DEATH* was as follows:

Paralysis (duration) yrs. 2 mos 8 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Tompkins M. D.

5/30 1923 (Address) 1014 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Glen | DATE OF BURIAL: May 31 1923

20 UNDERTAKER: Sam'l H. Cassell Sons | ADDRESS: 1400 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76258

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. NAUMANN 90 D76258

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3143 Sloffard ST., 1670 WARD)

2-FULL NAME Henry Naumann

(a) RESIDENCE No. 3143 Sloffard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Neuman

6 DATE OF BIRTH (month, day, and year): March 18 67

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ....min.
	81	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Henry Naumann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Hertlay

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Sarah C. Wittstadt (Address): 3406 Wilkens Ave

15 Filed MAY 13 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 9th 23

17 I HEREBY CERTIFY, That I attended deceased from April 2 1923 to May 9 1923 that I last saw him alive on May 9 1923 and that death occurred, on the date stated above, at 4.30 A.m.

The CAUSE OF DEATH was as follows:

Acute Myocardial Degeneration

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary): Valvular Heart Disease

(duration) Not Known yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W. Jones M. D.

(Address) Druid Hill Ave

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Louden Park. Cem.

DATE OF BURIAL: June 1st 1923

20 UNDERTAKER: C. W. Dill.

ADDRESS 3109 Frederick Ave

No. 15.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76259

CERTIFICATE OF DEATH.

38 D76259

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 934 Druid Hill Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lucy Myers

(Residence in Baltimore: No. 934 Druid Hill Ave St.; 44 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col

5-~~SINGLE~~, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, October 6, 1879 (Month) (Day) (Year)

7-AGE, 44 yrs. mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House Keeping
(b) General nature of industry, business, or establishment in which employed (or employer)..... Home Keeping

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Lucy Vessel

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Chappell

(Address) 934 Druid Hill Ave

15-

FILED MAY 31 1923 GG

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 28, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 11, 1923, to May 28, 1923, that I saw h.r alive on May 27, 1923, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. Scott Hall M. D.

May 31, 1923 (Address) 384 N. Gilmor

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, May 31, 1923

20-UNDERTAKER Mrs. R. G. Elliott — ADDRESS 1722 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

(Hans)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76260

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. D76260

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) John Hopkins Hosp. ST., 9 WARD) 26

2-FULL NAME Walter Hans. (Off 21st + Fait Ave) city

(a) RESIDENCE NO. Hudson Heights, Cliff ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Andrew Hans (Father)

6 DATE OF BIRTH (month, day, and year) Oct. 1, 1922.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
—	7.	29.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER Andrew Hans.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Echat.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Records.

15 MAY 31 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30, 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1923. to May 30, 1923. that I last saw him alive on May 30, 1923. and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Rickets

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	May 31 1923

20 UNDERTAKER John M. Weber ADDRESS 1803 Bank

H 06263

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76261

CERTIFICATE OF DEATH.

75-00 D76261.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Pennington

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record

(Address) Bay View

15 Filed MAY 31 1923 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1923

17

I HEREBY CERTIFY, That I attended deceased from May 24, 1923, to May 29, 1923.

that I last saw h[illegible] alive on May 29, 1923

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Hypertension

Residual Hemiplegia (Right)

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McPowell M. D.

, 19 (Address) Municipal Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem	5/31 1923
20 UNDERTAKER	ADDRESS
Chas. P. Evans & Son	11 Mont Royal Ave

GIVE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76262

CERTIFICATE OF DEATH.

90 D76262

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1300 Light ST. 23 WARD)

2-FULL NAME Georgeanna Bagley

(a) RESIDENCE No. 1300 Light ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER Benson Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER Fannie Hirsch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant Mrs. Becker

(Address) 1511 Clarkson St

15 Filed MAY 31 1923 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1923

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1920, to May 28, 1923, that I last saw her alive on May 28, 1923, and that death occurred, on the date stated above, at 8 p m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) decompensation

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? phy

(Signed) W. H. Baglen, M. D.

5/31. 1923 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: May 31 1923

20 UNDERTAKER: Margaret L. Floyd — ADDRESS: 1422 Light

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Scheinin)

D76263

HEALTH DEPARTMENT—CITY OF BALTIMORE

1 18 001 D76263

CERTIFICATE OF DEATH

1-PLACE OF DEATH Hebrew Hosp Monument & Ballard

REGISTERED NO.

CITY OF BALTIMORE: (No. ... St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Jertie Scheinen

(a) RESIDENCE NO. 1431 Central Ave St., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 11 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Jacob Scheinin

6 DATE OF BIRTH (month, day, and year): 1882

7 AGE: Years 41 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): ...

(c) Name of employer: ...

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Morris Belinski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: ...

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis
(Address): 1439 E Baltimore St

15 Filed MAY 31 1923, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31 1923

17

I HEREBY CERTIFY, That I attended deceased from May 27th, 1923 to May 31st 1923.

that I last saw her alive on May 31st, 1923.

and that death occurred, on the date stated above, at 8 30 m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of May 31st 23

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) A Haller Longstreet M. D.

, 19 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale | DATE OF BURIAL: May 31 1923

20 UNDERTAKER: Jack Lewis | ADDRESS: 1439 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Umbilical Hernia

Spec.—1-10-21 M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76264

CERTIFICATE OF DEATH.

101-001 D76264

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Brown

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records.
(Address)

15 MAY 31 1923 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1923

17

I HEREBY CERTIFY, That I attended deceased from May 29, 1923, to May 27, 1923, that I last saw her alive on May 26, 1923, and that death occurred, on the date stated above, at 1:10 A.M. The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McPowell, M. D.

5-28-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
UNIVERSITY OF MARYLAND.	
20 UNDERTAKER Commissioner Health.	ADDRESS MAY 31 1923

Muriel Perrit Clem

427

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D76265

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76265

CERTIFICATE OF DEATH.

129

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 114 Collins ave St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Vogelsang

(a) Residence No. 114 Collins ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Mar.

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John Vogelsang

6-DATE OF BIRTH (month, day and year) Nov 25 1863

7-AGE, 59 yrs. 6 mos. 4 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS:

10-NAME OF FATHER, Gottlieb Eitel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) John Vogelsang

(Address) 114 Collins ave

15- Robert F. Harrison, 192

Registrar.

Burial Permit Clerk.

MAY 31 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 29 23

I HEREBY CERTIFY, That I attended deceased from May 25 1923 to May 29 1923

that I last saw h[illegible] alive on May 29 1923

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Uraemia

(No terminal Paralysis)

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W. Jones M.D.

May 29 23 (Address) 222 Aisquith St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Olivet Cemetery

DATE OF BURIAL. May 31 1923

20-UNDERTAKER. F. A. Krause & Son

ADDRESS 703 Hanover St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76266

D76266

CERTIFICATE OF DEATH

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 Myrtle ave. ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Randolph

(a) RESIDENCE. No. 1401 Myrtle ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Randolph 1863

6 DATE OF BIRTH (month, day, and year) May 12 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60 ~~62~~	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stockcarrier

(b) General nature of industry, business, or establishment in which employed (or employer) Contracting

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Henry Randolph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Fannie Strange

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Wid'a Randolph (Daughter) (Address) 1401 Myrtle Ave

Robert P. Harrison,

15 Filed MAY 3 1923 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1 1923 to May 24 1923

that I last saw him alive on May 19 1923

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage.

(duration) 2 hrs.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of 5/19/23

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Sinkler & Blake M. D.

19 (Address) 1014 W Fa Sayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	May 5 1923
20 UNDERTAKER Jno. M. Johnson	ADDRESS 1309 Druid Hill Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1012 W. Lafeyette Ave.,
Baltimore, Md.,

July 29th, 1923.

C. Hampson Jones, M. D.
Commissioner of Health,
Baltimore, Md.
Dear Sir;-

Will you kindly change the date of the year of birth of John Randolph, who died in your city on the 29th of May, 1923, from 1861 to 1863and the age from 62 years 2 months 17 days to 60 years 2 months 17 days, and oblige,

Yours very respectfully,

Herbert S. Blake M.D.
Attending Physician.

Spec.—1-10-21—M&T—1500 Bks.

D76267

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D76267

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1020 S. Charles ST., 23 WARD)

2-FULL NAME Nellie E. Tall

(a) RESIDENCE NO. 1020 S. Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William S. Tall.

6 DATE OF BIRTH (month, day, and year) Feb 7 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sonneborn Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Daniel S Kimball

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lena V Chambers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Robert B Kramer

(Address) 1020 S Charles St.

MAY 31 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1922, to May 30, 1923, that I last saw h[illegible] alive on May 30, 1923, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs & symptoms Laboratory tests

5/30/23 19 (Signed) J Edward Jones, M. D.

(Address) 1430 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL June 2 1923

20 UNDERTAKER Law McCully ADDRESS 130 E. Fort Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76268 31 D76268

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 E Randall ST. 23 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma A Eberlein

(a) RESIDENCE. NO. 16 E Randall ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 4 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 17th 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frederick W Eberlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Theresa Berner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Fred W Eberlein
(Address) 16 E Randall st.

15 Filed Robert E. Garrison, Registrar

5 31 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1923

17 I HEREBY CERTIFY, That I attended deceased from March, 19 23, to May 30, 1923, that I last saw her alive on May 30, 1923, and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Temple Swift M. D.

May 31 1923 (Address) 1430 Mary Land Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	June 2nd 1923
UNDERTAKER	ADDRESS
E Schlosman's Son	Hanover

NAME—THIS IS A PERMANENT RECORD. EXACT form of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] CPA. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76269

CERTIFICATE OF DEATH.

129 D76269

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 N. Hamburg St. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James C. McKeldin

(a) RESIDENCE. No. 615 N. Hamburg St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora McKeldin

6 DATE OF BIRTH (month, day, and year) March 29th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward A. McKeldin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Sophia Wolf.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Dora McKeldin
(Address) 615 N Hamburg St

15 Filed MAY 31 1923

16 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1923, to May 30, 1923

that I last saw him alive on May 29, 1923

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M. Rosenbach, M. D.

May 31, 1923 (Address) 1211 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	June 2nd 1923
20 UNDERTAKER E. Schloman & Son	ADDRESS 1039 Hanover St

NOTICE—THIS IS A PERMANENT RECORD. Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76270

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

36-005 D76270

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD) 12

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lottie K. Meeks.

(a) RESIDENCE NO. 408 E. 31st. Street ST.; WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harvey Meeks.

6 DATE OF BIRTH (month, day, and year): Aug. 6" 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or min.
	43	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Tenn.

PARENTS

10 NAME OF FATHER: Frederick L. Galton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Tenn

12 MAIDEN NAME OF MOTHER: Florence Reip

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Hospital Records (Address) Lombard & Greene Sts.

15 Filed ..... 19 ..... Robert F. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 30 1923

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1923, to May 30, 1923.

that I last saw her alive on May 30, 1923

and that death occurred, on the date stated above, at 1:10 A. m.

The CAUSE OF DEATH* was as follows:

Salpingitis, tuberculous

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Peritonitis tuberculous intestinal obstruction due to adhesions (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Rome

Did an operation precede death? Yes Date of May 25/23

Was there an autopsy? no.

What test confirmed diagnosis? Oper. & Clinical

(Signed) Geo. G. Halley M. D.

(Address) Univ. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: June 1 1923

20 UNDERTAKER: Joseph B. Cook ADDRESS: 1003 N. Gilto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 31 1923

Spec.—1-10-21—M&T—1500 Rks. (Margaret B. Heaps)

D76271

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. X / 24

D76271

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hospital (St.) 14 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Hugh I. Heaps (Margaret Barton)

(a) RESIDENCE NO. Street, Md. ST., WARD Stem Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hugh I. Heaps.

6 DATE OF BIRTH (month, day, and year) March 6, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Mr. Thomas Barton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Hannah Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Pearl Heaps

(Address) 1505 Bolton St

15 MAY 31 1923 Robert P. Lattibur

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1923

17 I HEREBY CERTIFY, That I attended deceased from May 15 , 1923 , to May 31 , 1923 , that I last saw h.. alive on May 31 , 1923 , and that death occurred, on the date stated above, at 11.55 a. m.

The CAUSE OF DEATH* was as follows:

Multilocular Cyst of Liver

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cholaemia, Terminal bronchopneumonia (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/26/23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. S. Price , M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Delta Pa — DATE OF BURIAL June / 1923

20 UNDERTAKER Wm. J. Hickman & Son — ADDRESS North St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76272

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76272

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hos. ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Anna M. Sauer (Sauer)

(a) RESIDENCE No. 1803 Mosher St. Balt. Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8-1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30 yrs.	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Richard Sauer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Annie Straehle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Richard Sauer Jr 1803 Mosher

15 Filed 1923 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29th 1923

17

I HEREBY CERTIFY, That I attended deceased from April 28, 1923, to May 29, 1923, that I last saw her alive on May 29, 1923, and that death occurred, on the date stated above, at 8 0, m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Abe. Rentantis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward F. Cantwell, M. D.

19 Address St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: June 19 23

20 UNDERTAKER: Wm J Gickens & Bro

ADDRESS: N. Pa

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76273

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76273

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2026 Cliftwood Av ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Faherty

(a) RESIDENCE NO. 2026 Cliftwood Av ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item must be carefully supplied. PHYSICIAN should be stated EXACTLY. AGE should be stated EXACTLY. PHYSICIAN'S address and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

F. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S address and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Faherty

6 DATE OF BIRTH (month, day, and year) Dec. 1863

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
60	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Cornelius McCauliffe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Cullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Patrick Faherty (Address) 2026 Cliftwood Av

15 MAY 31 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 18 1923 to May 28 1923.

that I last saw h alive on May 28 1923.

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

General Carcinoma

Duration yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted —

if not at place of death?

Did an operation precede death? not Date of 3 years ago removal cancer breast

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Riley, M. D.

May 30, 1923 (Address) 1628 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Catholic Cemetery	6/1/1923

20 UNDERTAKER C. D. Fanning & Son - 1938 E. Lafayette Ave

ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Lasagy).

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76274 D76274

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1039 Guilford St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Lusagy

(a) RESIDENCE. No. 1039 Guilford St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 9th 1878

7 AGE: Years 45; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Wm. J. Lasagy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Kenna

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Miss Margaret Lasagy

(Address): 1039 Guilford Ave.

15 Filed , 19 Registrar

Burial Permit Given.

MAY 31 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31 1923

17 I HEREBY CERTIFY, That I attended deceased from April 18 . 1923 . to May 31 . 1923 . that I last saw him alive on May 30 . 1923 . and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

(duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? Bacilli Tuberculosis

(Signed) V. Dan Williams, M. D.

, 19 (Address) 601 Cedra Allan Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: 6/2/23

20 UNDERTAKER: C. D. Fanning & Son - 1938 E. Lafayette — ADDRESS

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76275 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D76275

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 10 32

City of BALTIMORE: (No. Municipal Hospital St., 10 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME — Nora Allen

(a) Residence No. 1312 Ashland Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (Write the word.) ?

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Sylvester Allen

6-DATE OF BIRTH (month, day and year): ?

7-AGE: 24? yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Virginia

PARENTS

10-NAME OF FATHER: S W. Barnes

11-BIRTHPLACE OF FATHER (city or town) (State or Country): ? Virginia

12-MAIDEN NAME OF MOTHER: ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): ?

14- (Informant) Municipal Hospital Records

(Address)

15- Robert P. Harrison, M.D. Registrar.

MAY 31 1923

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): May 31, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 29 1923 to May 31 1923 that I last saw h.. alive on May 30 1923 and that death occurred, on the date stated above, at 1:00 A.M.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Meningitis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. McPowell M. D

(Address) 5-31-1923 Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County — DATE OF BURIAL: June 2nd 1923

20-UNDERTAKER: George Schulting & Sons — ADDRESS: 1156 E. Monument St.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Tubercular.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76276

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76276

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1633 w. Fayette ST.: 19 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Mc Henry

(a) RESIDENCE. No 1633 w. Fayette St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael J. McHenry

6 DATE OF BIRTH (month, day, and year): March 28. 1844

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: William Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Vincent McHenry
(Address) 1633 W. Fayette St.

15 By: Robert P. Garrison, Registrar

MAY 31 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 29 19

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1. 23, 19, to May 29, 19 23

that I last saw her alive on May 29, 19 23

and that death occurred, on the date stated above, at 5.20 P m

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
Auricular Fibrillation

(duration) about 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Surgical Findings

(Signed) J. Edward Norris, M. D.

5/30. 1923 (Address) 1430 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	May 31 1923

20 UNDERTAKER: Margaret L. Flynn

ADDRESS: 1422 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76277 ✓ 231 D76277

CERTIFICATE OF DEATH

1-PLACE OF DEATH Fairfield Md REGISTERED NO.

CITY OF BALTIMORE: (No. 6 st near Chesapeake ST. or 23 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret C Wright

(a) RESIDENCE NO. 6 st near Chesapeake st WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James F Wright

6 DATE OF BIRTH (month, day, and year) April 6 1901

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
22	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Maryland

PARENTS

10 NAME OF FATHER William Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Maryland

12 MAIDEN NAME OF MOTHER Georgie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co Maryland

14 Informant James F Wright

(Address) 6 st near Chesapeake st

15 Filed MAY 31 1923, 19 Robert P. Garrison, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1923

17 I HEREBY CERTIFY, That I attended deceased from April 3rd 1923. to May 31. 1923.

that I last saw her alive on May 30. 1923.

and that death occurred, on the date stated above, at 10 45 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William A Scott M. D.

May 31 1923 (Address) 816 Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Church Home Via Bexa RR — DATE OF BURIAL June 2 1923

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76278

CERTIFICATE OF DEATH.

191-001 D76278

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1425 Reynolds St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Gralewski

(a) Residence No. 1425 Reynolds St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Eugenia Gralewski

6-DATE OF BIRTH (month, day and year) March 18, 1887

7-AGE. 36 yrs. 1 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sturdor

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Andrew Gralewski

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Frances Vinskoska

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Poland

14- (Informant)..... Elizabeth Gralewski

(Address)..... 1425 Reynolds.

15- Robert E. Miller

Filed ..... 192.... Registrar.

MAY 3 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 29. 1923

17- I HEREBY CERTIFY, That I attended deceased from May 25 1923 to May 29 1923 that I last saw him alive on May 29 1923 and that death occurred, on the date stated above, at 5 30 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(Duration) yrs. mos. 2 hours ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None.

(Signed) Thos. F. Stevens M. D

5/30. 1923 (Address) 2878 Hayford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Rosary Cemetery	June 1, 1923
20-UNDERTAKER.	ADDRESS
Am. Fialkowski	1618 Eastern Ave.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-1927—M&T—[illegible]

Dr Gaither md Gen v Biddle

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D76279

CERTIFICATE OF DEATH.

63

D76279

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 Linden av ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Woodard

(a) RESIDENCE NO. 1511 Linden av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Thomas Woodard

6 DATE OF BIRTH (month, day, and year): Sept 29th 1874

7 AGE: Years 48 Months 8 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Geo. Rohrbach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Carrie Lawrence

(Address) 1511 Linden av

15 Registrar: [illegible] MAY 31 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 29 1923

17

I HEREBY CERTIFY, That I attended deceased from May 15 1923, to May 29 1923,

that I last saw h[illegible] alive on May 29 1923,

and that death occurred, on the date stated above, at 9 PM m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

Secondary Disease

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O'Neal & Gaither, M. D.

(Address) #17 N. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: June 1st 1923

20 UNDERTAKER: F. S. Hepplet — ADDRESS: 2336 Fred'k av

Robert P. Hartigan, Buried Permit Clerk

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76280

CERTIFICATE OF DEATH.

101-001

D76280

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 Pierce St. 18 Ward)

2-FULL NAME George Peters

(a) RESIDENCE. No. 924 Pierce St. Ward

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Frances Peters

6 DATE OF BIRTH (month, day, and year): Dec 25, 1866

7 AGE: Years 47 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: furniture mover

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Kaufman Furniture Moving Co. Howard Co.

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Charles Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co Maryland

12 MAIDEN NAME OF MOTHER: Marie Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co Maryland

14 Informant (Address): Mrs Frances Peters 924 Pierce St

15 Filed JUN 1 - 1923 JOSEPH R. KRANTZ Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, dny, nnd yenr): May 31 1923

17 I HEREBY CERTIFY, That I attended deceased from May 21 1923, to May 31 1923, that I last saw h. alive on May 30th 1923 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) John E. Lafferty M. D.

19 (Address) 1403 N Milton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: June 1 - 1923

20 UNDERTAKER: Daniel Easton — ADDRESS 916 Pierce

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76281 ✓ 129 D76281

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 432 W. Monument St., 17 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Hollis

(a) Residence No. 552 St. Mary's Ct St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1869

7-AGE, 54 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) & (State or Country) Bath City

PARENTS.

10-NAME OF FATHER Wm Hollis

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (City or town) (State or Country) Unknown

14-

(Informant) Mrs Hollis

(Address) 552 St Mary's Ct

15-

JUN 1 1923 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 29, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 28 1923 to May 29 1923

that I last saw h living on May 28 1923

and that death occurred, on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Endocarditis & nephritis

Indefinite (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) John Kloss M. D.

, 19 (Address) 752 George St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) **whether Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 6-1-, 19 23
Mt Auburn Cem	
20-UNDERTAKER.	ADDRESS
Jesse Eaves	Bene

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76282

CERTIFICATE OF DEATH.

X 117 ✓ D76282

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (STREET) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rose Conaway

(a) RESIDENCE NO. Laurel Md St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. — mos. 8 ds. How long in U. S., if of foreign birth? yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albinus Conaway.

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER J. McKnew

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Selby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Records (Address)

15 Filed JUN 1-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1923, to May 31, 1923 that I last saw h alive on May 31, 1923 and that death occurred, on the date stated above, at 7:10 P m

The CAUSE OF DEATH* was as follows:

Appendicular abscess.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cordiac insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of May 26, 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation Signs.

(Signed) B. M. Rhodes M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Md. DATE OF BURIAL 6-1 1923

20 UNDERTAKER Earle ADDRESS 115 E West St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76283

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76283

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mount Hope Retreat ST. 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Rehill

(a) RESIDENCE. NO. Mt Hope Retreat ST. 28 WARD. Green Ridge Md.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Born Ireland ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
abt	69	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer) R. work.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) (?) Ireland.

PARENTS

10 NAME OF FATHER Michael Rehill

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen McConnad

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Ireland.

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md.

15 Filed JUN 1 - 1923 19 ROBERT R. KRANTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31st 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 7th 1896 to May 31st 1923, that I last saw her alive on May 20 1923, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Suddenly - (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Dfr. Psychosis.

abt (duration) 28 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Penna (?)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

May 31, 1923 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	June 1 1923
20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOOD, Successor)	ADDRESS 108 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Blks.

D76284

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76284

CERTIFICATE OF DEATH.

74-00

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Maggie Druton

(a) RESIDENCE. NO. Mt Hope Retreat ST. 28th WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 79 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Col	79	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md.

PARENTS

10 NAME OF FATHER George Druton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER M. E. La Vielle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md.

14 Informant Records of Mt Hope Retreat
(Address) Baltimore Md.

15 Filed JUN 1 - 1923 . 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1923

17

I HEREBY CERTIFY, That I attended deceased from May 1890, 19..., to May 31, 1923.

that I last saw h[illegible] alive on May 31, 1923.

and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage with R. Hemiplegia.

(durntion) 2 yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary) Senile Psychosis.

Post Mortem Manif. (duration) 37 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What lest confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL June 2 1923

20 UNDERTAKER STEWART & MOWER COMPANY
(WILLIAM F. WOOSLEY, Successor)

ADDRESS 106 W. NORTH AVE.

CAUTION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76285 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 74-901 D76285

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 936 Brooks Lane St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Burke

(a) Residence No. 936 Brooks Lane St., 13 Ward. Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 77 yrs. 6 mos. 23 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word): Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James Burke

6-DATE OF BIRTH (month, day and year) Nov-8-1845

7-AGE: 77 yrs. 6 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): " "
(c) Name of employer: " "

9-BIRTHPLACE (city or town) (State or Country): Manchester Maryland

PARENTS

10-NAME OF FATHER: James Winter

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Emily Lineweaver

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-(Informant) Mrs. Mary A. Baer (daughter)
(Address) 936 Brooks Lane

15-Filed JUN 1 1923 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 31. 1923

17- I HEREBY CERTIFY, That I attended deceased from May 21 1923 to May 31 1923 that I last saw h. alive on May 31 1923 and that death occurred, on the date stated above, at 12.50 P m. The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) — yrs. — mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Necropsy

(Signed) Stelwagen F. Kuehnau M. D.

(Address) 6 E. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: June-1-23

20-UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) — ADDRESS: 108 W. LEXINGTON ST.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be in plain terms, so that it may be properly classified. Exact statement of OCCUPA instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76286

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76286

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 2704

CITY OF BALTIMORE: (No. ~~1407~~ Elliott ST., 1 WARD)

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. O'Connor

(a) RESIDENCE No. 2407 Foster Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christena O'Connor

6 DATE OF BIRTH (month, day, and year) April 15-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William O'Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Catherine McWilliams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Christena O'Connor

(Address) 2407 Foster Ave.

15 Filed JUN 1-1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1923

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1923, to May 29th 1923, that I last saw him alive on May 28th, 1923, and that death occurred, on the date stated above, at 6 30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray. Sputum Exam.

(Signed) D. W. Jones M. D.

5/31/1923 (Address) 1011 N. Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem. DATE OF BURIAL: June 1923

20 UNDERTAKER: H. Sander Sons ADDRESS: 1710 Pennsylvania

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76287

CERTIFICATE OF DEATH.

161-001 D76287

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 201 S. Bouldin ST., 26 WARD)

2-FULL NAME Johanna Haberkam

(a) RESIDENCE NO. 201 S. Bouldin ST. 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 25 1923

7 AGE — Years — Months — Days: 2 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: John L. Haberkam

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Amelia Shimek

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mrs Amelia Haberkam

(Address) 201 S. Bouldin St

15 Filed JUN 1-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 27 1923

17

I HEREBY CERTIFY, That I attended deceased from May 25, 1923, to May 27, 1923, that I last saw h alive on May 27, 1923 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

6 month Foetus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Jetton M. D.

5/29, 1923 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Johns Hopkins Embry Dept — DATE OF BURIAL: 5/28 1923

20 UNDERTAKER — ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D76288

D76288

CERTIFICATE OF DEATH

1-PLACE OF DEATH 402 W. Lexington St. REGISTERED NO.

CITY OF BALTIMORE: (No. 402 W. Lexington St ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Jung.

(a) RESIDENCE. No. 402 W. Lexington St ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Femal	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis W. Jung

6 DATE OF BIRTH (month, day, and year) August 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	9.	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER John H. Mangold

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Sophia Ball

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Louis W. Jung
(Address) 402 W. Lexington St.

15 JUN 1-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 20, 1922, to May 30, 1923, that I last saw her alive on May 28, 1923, and that death occurred, on the date stated above, at 10:45 P. m.

The CAUSE OF DEATH* was as follows:

Organic disease of Heart.
Valvular

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Heart Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No test needed

(Signed) J. Howard Hayward M. D.

May 31 1923 (Address) 1809 Ballon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 2 1923

20 UNDERTAKER	ADDRESS
Josiah Pyfer.	16 W. North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILED

Spec.—1-10-21—M&T—1500 Bks.

D76289

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D76289

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No. Broadway & Fairmount WARD) 7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr John E. Gordon (Gordon)

(a) RESIDENCE NO. 511 N. Wolfe ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Catherine R. Gordon

6 DATE OF BIRTH (month, day, and year) Sept 26/93

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wood Pattern

(b) General nature of industry, business, or establishment in which employed (or employer): Maker

(c) Name of employer: U.S. Goverment

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: John Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country): D.C.

12 MAIDEN NAME OF MOTHER: Julia

13 BIRTHPLACE OF MOTHER (city or town) (State or country): D.C.

14 Informant: Catherine R. Gordon

(Address) 511 N. Wolfe St

1-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31st 1923

17

I HEREBY CERTIFY, That I attended deceased from May 28th, 1923, to May 31st, 1923,

that I last saw h m alive on May 31st, 1923

and that death occurred, on the date stated above, at 2.45 P.m.

The CAUSE OF DEATH* was as follows:

Acute Myeloid Leukaemia

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory and Phy. Findings

(Signed) K.C. Rice, M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem. DATE OF BURIAL 6/4 1923

20 UNDERTAKER: Philip Stenig ADDRESS 2016 Orleans

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

K·S·A

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76290

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76290

CERTIFICATE OF DEATH.

REGISTERED No. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 35 N. Caralin ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Shaffer

(a) RESIDENCE. No. 35 N. Caralin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	C.	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George Shaffer

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Marys Co. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) " Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " Unknown

14 Informant Herman Cullison
(Address) 35 N. Caralin St

15 Filed JUN 1-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1923, to May 30, 1923, that I last saw h[illegible] alive on May 30, 1923, and that death occurred, on the date stated above, at 7-30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Yellow Atrophy of the Liver.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J. Green, M. D.

5-30-1923 (Address) 120 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	June 1 1923

20 UNDERTAKER John W Henderson ADDRESS 1502 Monument

No 0216

NOTICE TO PHYSICIANS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D76291

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D76291

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital 10 St., Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Hutton

(a) Residence No. 1206 St. James St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Black	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) ?

7-AGE. 65-? yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). (State or Country), Patapsco Neck, Md

PARENTS

10-NAME OF FATHER, Jim Buck

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Maryland

14- (Informant) Emma Thompson

(Address) 1206 St. James Street

15- Filed JUN 1-1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 29 1923

17- I HEREBY CERTIFY, That I attended deceased from May 26, 1923, to May 29 1923, that I last saw h[illegible] alive on May 29, 1923, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H McPowell M. D

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Int-Given Cemetery	June 2 1923
20-UNDERTAKER.	ADDRESS
Mrs Robert J Elliott	Ashland Va

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76292 — 31 — D76292

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1045 Argyle Ave ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hamilton L. Caution

(a) RESIDENCE NO. 1045 Argyle Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? 69 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary B. Caution

6 DATE OF BIRTH (month, day, and year) May 10, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	52	0	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Hamilton L. Caution

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Martha L. Broton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Gustave L. Caution (Address) 1211 Division St

15 Filed JUN 1 - 1923 ROBERT R. KRAUTER. Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 17th, 1923, to May 28th, 1923, that I last saw him alive on May 20th, 1923, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows: Pul. Tuberculosis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. L. Elliott, M. D.

5/29, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL June 1923

20 UNDERTAKER Mrs Robert A Elliott — ADDRESS 725 Ashland Ave

N. B.—WHETHER BURIED, WITH ENGRAVING—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76293 ✓ 89 D76293

D76293

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 104 N Poppon St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Kelley

(Residence in Baltimore: No. 104 N Poppon St., 42 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Nov (Month) 3 (Day) 1880 (Year)

7-AGE. 42 yrs. 6 mos. 28 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ins. agent
(b) General nature of industry, business, or establishment in which employed (or employer): Chicago Nat.

9-BIRTHPLACE, (State or Country). Balt. City

PARENTS.

10-NAME OF FATHER. Samuel Kelley

11-BIRTHPLACE OF FATHER, (State or Country). unknown

12-MAIDEN NAME OF MOTHER. Elizabeth McCausland

13-BIRTHPLACE OF MOTHER, (State or Country). Balto City

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Helen Kelley

(Address) 104 N Poppon St

15-JUN 1-1923

Filed ..... 192.... ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 1 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Rupture of Coronary

Contributing (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Reuben M. Penton M. D. (Coroner)

May 1 192 3 (Address) 707 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. New Cathedral DATE OF BURIAL. June 4 1923

20-UNDERTAKER. W.A. Pickrell & Son ADDRESS Mount St Pa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 ✓ D76294

D76294

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Balto Md ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clyde Stanley

(a) RESIDENCE NO. 1717 W Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Sept 23-1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Scholboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Walter Stanley

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Viola Alexander

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant (Address) 1717 Saratoga St

15 JUN 1-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/29 23

17 I HEREBY CERTIFY, That I attended deceased from 5/28, 19 23, to 5/29, 19 23.

that I last saw h alive on 5/29, 19 23.

and that death occurred, on the date stated above, at 11-50 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy & Lab. findings

(Signed) Iron Bridges, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	6-1 1923
20 UNDERTAKER Harry L. Nitzke	ADDRESS 1531 W Lombard St

N. B.—WHEN FILLING, WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76295

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001 D76295

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 North Broadway ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Mecaslin

(a) RESIDENCE NO. 719 North Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 3 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adolph Mecaslin

6 DATE OF BIRTH (month, day, and year) Feb. 2, 1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
75	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas Bond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Elizabeth Crosby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant George W. Bond

(Address) 719 N. Bond St.

15 JUN 1 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 16th, 1923, to May 30th, 1923, that I last saw h[illegible] alive on May 30th, 1923, and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Diffuse Bronchitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. W. Glover, M. D.

June 1 1923 (Address) 501 E. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	June 1 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 W. Calvert

INFORMATION, WITH REGARD TO—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76296

100-001 ✓ D76293

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital (St. or Hospital) (WARD)

2-FULL NAME Oscar Johnson

(a) RESIDENCE NO. 834 Pine St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hosea A. Johnson.

6 DATE OF BIRTH (month, day, and year): 1887

7 AGE: Years 36; Months —; Days —; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: James Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Holletag

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Hospital Records.

(Address)

15 Filed JUN 1 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 30, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1923 to May 30, 1923 that I last saw him alive on May 30, 1923, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Sybocute Cervical Lymphadenitis.

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of May 14/1923

Was there an autopsy? No

What test confirmed diagnosis? Operation & Signs

(Signed) B. M. Rodes, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: June 3 1923

20 UNDERTAKER: Brown & Sheeland

ADDRESS 114 N.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76297

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76297

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frederick Fuller

(Residence in Baltimore. No. 1523 W Lexington St.; yrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH. Oct (Month) 18 (Day) 1881 (Year)

7-AGE. 31 yrs. 7 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Md Dry Dock Co

9-BIRTHPLACE. (State or Country): North Carolina

PARENTS.

10-NAME OF FATHER. Dock Fuller

11-BIRTHPLACE OF FATHER. (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER. Emma Gloars

13-BIRTHPLACE OF MOTHER. (State or Country). North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Fuller

(Address) 1523 W Lexington St

Filed JUN 1-1923 192.. ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May (Month) 31 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet Wound through Lungs Liver

Homicide

(Duration) ..yrs. mos 10 hrs

CONTRIBUTORY (Secondary) Internal Hemorrhage

(Duration) ..yrs. mos 10 hrs

(Signed) James M Fenton M. D. (Coroner.)

May 31 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents) At place of death ....yrs. ....mos. 10 dys In the state....yrs....mos....ds.

Where was disease contracted, if not at place of death? 949 W Lexington St

Former or usual residence 1523 W Lexington St

19-PLACE OF BURIAL OR REMOVAL. Offord N. Carolina DATE OF BURIAL. June 2 1923

20-UNDERTAKER. Brown & Friedel Schroeder ADDRESS 114 or

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D76298

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D76298

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2016 Harlem Ave. ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace A. Hosmer

(a) RESIDENCE No. 2016 Harlem Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred: Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline A. Hosmer

6 DATE OF BIRTH (month, day, and year) Apr. 17" 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired (Travelling

(b) General nature of industry, business, or establishment in which employed (or employer) Ins.)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Albert N. Hosmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Windsor Vermont

12 MAIDEN NAME OF MOTHER Margaret Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alexandria Va.

14 Informant Horace O. Hosmer

(Address) 2016 Harlem Ave.

15 JUN 4 1923 . 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1921 to May 31 1923.

that I last saw h in alive on May 31st 1923,

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia - Arteria sclerosis.

(duration) 10 yrs. — mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —.

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) Wm A. Howell, M. D.

5/31 19 23 (Address) 3523 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	June 2" 1923
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W. Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76299

CERTIFICATE OF DEATH.

90 D76299

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2113 N. Fulton Ave. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Elizabeth Slade

(a) RESIDENCE NO. 2113 N. Fulton Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 15" 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER Luther M. Slade

11 BIRTHPLACE OF FATHER (city or town) Harford Co
(State or country) Md.

12 MAIDEN NAME OF MOTHER Keturah Triplett

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Md.

14 Informant Miss Olla B. Slade
(Address) 2113 N. Fulton Ave.

15 Filed JUN 1 1923, 19 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31" 1923

17 I HEREBY CERTIFY, That I attended deceased from Octob 1, 1921, to May 31, 1923.

that I last saw her alive on May 29, 1923.

and that death occurred, on the date stated above, at 5.15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

CONTRIBUTORY (Secondary) (duration) 1 yrs. 8 mos ds.

Right ~~Left~~ hemiplegia (Thrombus?)

(duration) yrs. 3 mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. C. Pole, M. D.

(Address) 2034 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL June 1 1923

20 UNDERTAKER Jos B Cook

ADDRESS 1003 W Balto

...mation should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ... ns on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76300

CERTIFICATE OF DEATH.

3 | D76300

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 508 E. Eager ST., 10 WARD)

2-FULL NAME Edmund - D. Saurin

(a) RESIDENCE No. 508 E. Eager st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 25 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	25.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Edmund Saurin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER May Dyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Mary Saurin

(Address) 508 E Eager st

15 Robert F. Harrison, .19 Registrar

Burial Permit [illegible]

N 1-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/28 .1923. to May 30 .1923.

that I last saw him alive on May 29 .1923.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) D Bernard Wilson M. D.

June 1 .1923 (Address) 914 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	June 2 1923

20 UNDERTAKER George F. Ruth ADDRESS 1735 Hayford Ave

IMPORTANT: This blank must be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76301

CERTIFICATE OF DEATH.

4+ D76301

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1830 Hope ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret M Dickard

(a) RESIDENCE. NO. 1830 Hope ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	married

3a If married, widowed, or divorced (or) WIFE of John Dickard

6 DATE OF BIRTH (month, day, and year) 6/24/1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Goncel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant John Dickard (Address) 1830 n Hope St

15 Filed ROBERT F. [illegible], Registrar

JUN 1-1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1923

17 I HEREBY CERTIFY, That I attended deceased from May 19th 1923 to May 30 1923 that I last saw her alive on May 30 1923 and that death occurred, on the date stated above, at 3.50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(duration) 4 yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insuff

(duration) yrs. mos. 11 ds

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs symptoms

(Signed) Jeanne Miller M. D.

, 19 (Address) 1806 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	June 2 1923

20 UNDERTAKER George J Ruth ADDRESS 1735 Harford Ave

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Lannon) ✓

Spec.—1-10-21—M&T—1500 Blks.

D76302

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76302

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE (No.) ..... ST., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Lannon

(a) RESIDENCE NO. 716 Milner Alley ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col.

5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teamster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do.

14 Informant (Address) Bay View Hospital Baltimore, Md.

15 Filed Robert F. Harrison, Registrar

1-1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 21, 1923 to May 29, 1923 that I last saw him alive on May 29, 1923 and that death occurred, on the date stated above, at 10-20 p.m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lues Confirmed

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann & Kahn & Citron

(Signed) H. Dodd M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Ct DATE OF BURIAL June 2 1923

20 UNDERTAKER E. L. Brown & Son ADDRESS 1811 W. Fayette St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76303

CERTIFICATE OF DEATH.

D76303

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 E. Lanvale ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Early Walsh

(a) RESIDENCE NO. 104 E. Lanvale ST., WARD.....

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 4 mos. 17 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah C. Daily

6 DATE OF BIRTH (month, day, and year) Jan. 14, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	63	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paymaster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer American Railway Express Co.

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Philip Walsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine O'Rourke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Ellen R. Coll

(Address) 104 E. Lanvale St.

15 Filed May 1 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30th 1923

17

I HEREBY CERTIFY, That I attended deceased from May 12th, 1923, to May 30th, 1923,

that I last saw him alive on May 30th, 1923,

and that death occurred, on the date stated above, at 2 - 6 p. m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver.

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency.

(duration) yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? Phila. Pa.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jno. Oldtand M. D.

May 31st, 1923 (Address) 40 W. Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	6/2, 1923
20 UNDERTAKER	**ADDRESS**
Henry W. Wears & Son	805 N. Calvert

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill in the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

16345 D76304

HEALTH DEPARTMENT—CITY OF BALTIMORE

JOHNS HOPKINS HOSPITAL

CERTIFICATE OF DEATH.

161-001 D76304

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 11 WARD)

2-FULL NAME Emma Stewart

(a) RESIDENCE NO. 1115 McCulloughST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred wife mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year) May 13-1923

7 AGE: Years — Months — Days 13

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Enla Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1923

17

I HEREBY CERTIFY, That I attended deceased from May 25, 1923, to May 26, 1923,

that I last saw her alive on May 26, 1923,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Melena Neonatorum

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Autopsy.

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS

Robert P. Harrison, Registrar

Burial Permit Clerk.

1-1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76305

CERTIFICATE OF DEATH.

162 D76305

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., 5 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Chase.

(a) RESIDENCE NO. 531 N. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 29-23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Johns Hopkins Hospital

PARENTS

10 NAME OF FATHER Braddy Cooper.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bengies Md.

12 MAIDEN NAME OF MOTHER Lucy Chase

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant (Address) W. W. Gray Johns Hopkins Hospital

15 Robert F. Harrison, Registrar

MAY 19 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1923, to May 10, 1923, that I last saw him alive on May 10, 1923, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Intra cranial hemorrhage

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) W. W. Gray, M. D.

Johns Hopkins Hospital

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health.

ADDRESS

MAY 19 1923

E. WOODALL

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

D76306 HEALTH DEPARTMENT—CITY OF BALTIMORE 66 D76306

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 50 So. Temple St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Chinn

(Residence in Baltimore: No. 50 So. Temple St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	Single

6-DATE OF BIRTH: Unknown ..... 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
about 35 yrs.....mos.....ds.	....hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

15- Robert P. Harrison, Registrar.

1-1923 Burial Permit Clerk. THE MORGUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 26 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) Geo. A. Horton M. D. (Coroner.)

May 30 1923 (Address) Curtis Bay, Balto. Md.

*State the Disease Causing Death, or, if Death Resulted from Violent Causes, state (1) Means of Injury; and whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
PUBLIC CEMETERY.	..... 19....

26-UNDERTAKER,	ADDRESS
Commissioner Health.	JUN 1-1923

D76307 HEALTH DEPARTMENT—CITY OF BALTIMORE D76307

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 210 Goodwood Rd. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Sullivan

(Residence in Baltimore: No. 1812 E. Lafayette Ave St., 55 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	married

6-DATE OF BIRTH. May 27/1858 (Month) (Day) (Year)

7-AGE. 65 yrs. mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer): Bridge building

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. John Sullivan

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Margaret Lynch

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nora Style

(Address) 1812 E. Lafayette Ave

15-

Filed Robert P. Harrison, Registrar.

1-1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May 30/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insuffiency

(Duration) yrs. 7 - 8 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia 2 yrs & 6 mons ago (Duration) yrs. mos. ds.

(Signed) J. S. Collins M. D.
(Coroner.)

6/1/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral Cem DATE OF BURIAL. 6/2 1923

20-UNDERTAKER. J. J. Moran ADDRESS 3000 E. Baltimore.

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21– E.B.R.S.—400 Blks.

D76308

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76308

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1216 Hollins St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Elmer Wersten

(a) Residence No. 1216 Hollins St., Ward 19
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5 ~~Single~~ Married, ~~Widowed, or Divorced,~~ (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mary Wersten

6-DATE OF BIRTH (month, day and year) Aug 23rd 1881

7-AGE. 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Fred W. Wersten

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Louise Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md

11- (Informant) R L Wersten

(Address) 106 W Randall st

15- Filed 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5/30/23.

17- I HEREBY CERTIFY, That I attended deceased from May 7 — 1923, to May 19 1923, that I last saw him alive on May 19 1923, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary.

Abt 6 (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Sputum. TB found.

(Signed) [illegible] M. D.

Jne, 1923 (Address) 11 E Penn St (Balt)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK	JUNE 2, 1923
20-UNDERTAKER. ROBERT BROOKS SON	ADDRESS 608 CALHOUN HOLLINS ST

N 1-1923

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76309

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76309

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 S. Bethel ST., W WARD)

REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antonio Piaskowski

(a) RESIDENCE No. 711 S. Bethel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Walter Piaskowski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Josephine Liksandor

13 BIRTHPLACE OF MOTHER (city or town) Austria (State or country)

14 Informant Walter Piaskowski
(Address) 711 S Bethel

15 Filed Robert P. Harrison, Registrar
Burial Permit Clerk.

1-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1923

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1923, to May 31, 1923,
that I last saw him alive on May 30, 1923
and that death occurred, on the date stated above, at 9 P. m.
The CAUSE OF DEATH* was as follows:
Cholera Infantum

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Rehberger, M. D.

, 19 (Address) 1709 Aliceanna St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	June 2 1923
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76310

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76310

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 834 W. Lexington St. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Howard Seabrease

(a) Residence No. 834 W. Lexington St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec. 29, 1921

7-AGE.	If LESS than 1 day,
1 yrs. 5 mos. ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Balto. Md.

PARENTS

10-NAME OF FATHER, Elmer Seabrease

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Agnes Herman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

14- (Informant)..... Mr. Elmer Seabrease

(Address)..... 834 W. Lexington St.

15- Filed..... 192 Robert P. Harrison, Registrar.

1-1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 31, 23

17- I HEREBY CERTIFY, That I attended deceased from April 9, 1923 to May 31, 1923 that I last saw him alive on May 31, 1923 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis

.....

.....

(Duration) yrs. 1 1/2 mos. ds

CONTRIBUTORY (Secondary) Convulsions

(Duration) yrs. mos. 2 ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. P. Cockeran M. D

6/1/, 1923 (Address) 24 N. Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	6-2-, 1923
20-UNDERTAKER.	ADDRESS 517
H. C. Brannigan Son	Schroeder St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76311 49 D76311

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2014 Bolton St., 13 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan I. Hecht

(a) RESIDENCE NO. 2014 Bolton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (Write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 2nd 1868

7 AGE — Years: 55 — Months: 0 — Days: 29 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Secretary of

(b) General nature of industry, business, or establishment in which employed (or employer): Alma Button Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Jacob Hecht

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Amelia Rosenau

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: B. Hecht (Address): 2014 Bolton St

15 Registrar: Robert P. Harrison,

Burial Permit Clerk.

N 1-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31st 23

17

I HEREBY CERTIFY, That I attended deceased from May 2 1923, to May 31 1923, that I last saw him alive on May 31 1923, and that death occurred, on the date stated above, at 8 10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of neck.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Carcinoma of lungs

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? Yes (3) Date of August-1922 Sept. 1922 Jan 1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical + pathological

(Signed) J Frederick Lentz, M. D.

6/1, 1923 (Address) 2040 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship — DATE OF BURIAL: June 3rd 1923

20 UNDERTAKER: David Sondheim — ADDRESS: 118 N Eutaw Royal Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76312

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76312

CERTIFICATE OF DEATH.

X 31

1-PLACE OF DEATH 28 S. Fulton Ave.,

CITY OF BALTIMORE: (No. 28 S. Fulton Ave., ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Molly Jane Ramy.

(a) RESIDENCE NO. Sperryville, Va., ST., WARD

(Usual place of abode) (If non-resident give city or town and State) Sperryville Va.

Length of residence in city or town where death occurred yrs. mos. 42 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of C. C. Ramy

6 DATE OF BIRTH (month, day, and year) July 31, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	64	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.,

PARENTS

10 NAME OF FATHER Thomas Pullman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Fannie Woodward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.,

14 Informant Elenor Dowd

(Address) 28 S. Fulton Ave.

15 Filed 1-1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1923

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1923, to May 31, 1923, that I last saw her alive on May 30, 1923, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Cirrhosis of Liver

Died of abscess of Lungs

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ows ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. H. Buckley, M. D.

, 19 (Address) 126 W Belvedere

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL June 2 1923

20 UNDERTAKER Harry H. Witzke — ADDRESS 1531 W Lombard St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Tuberculosis

D76313

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D76313

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 27 S Payson St., 20 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennie Hummel

(Residence in Baltimore: No. 27 S. Payson St., 40 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

6-DATE OF BIRTH. May (Month) 23 (Day) 1863 (Year)

7-AGE.	If LESS than 1 day,
60 yrs. ..... mos. 8 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE. (State or Country) Philadelphia Pa

PARENTS.

10-NAME OF FATHER, James Coulter

11-BIRTHPLACE OF FATHER. (State or Country) Philadelphia

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER. (State or Country) Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph H. Hummel

(Address) 27 S Payson st

15- Robert F. Harrison,

Filed ..... 192 ..... Registrar.

Burial Permit Clerk.

JE 2 1923

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 31 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Inflamatory Rheumatism

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Stenosis

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) James M Fenton M. D. (Coroner.)

May 31 1923 (Address) 700 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Park.	June 2, 1923

20-UNDERTAKER.	ADDRESS
Jos Fields	1200 W Fayette

Spec.—1-10-21—M&T—1500 Blks.

D76314

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-901 D76314

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1129 Somerset ST. 10 WARD)

2-FULL NAME Catherine A. Sanghirt

(a) RESIDENCE No. 1129 Somerset ST. 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 9 mos. 9 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (~~HUSBAND of~~) (or) WIFE of: Martin Sanghirt

6 DATE OF BIRTH (month, day, and year): Aug. 22nd 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Adam J. Feller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Feller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: M. Martin Sanghirt

(Address) 1129 Somerset St.

15 Filed JUN 2-1923

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from May 27. 1923. to June 1. 1923.

that I last saw h[illegible] alive on May 31. 1923.

and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary): Paralysis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theo. A. Hartmann, M. D.

June 1, 1923 (Address) 2214 Mayfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: June 4 1923

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 1301 E Eager

S. B.—WRITE PLAINLY, WITH PENCIL OR INK. ITEMS 1 to 20 must be answered. INFORMATION should be carefully supplied. AGE, OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D76315

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76315

CERTIFICATE OF DEATH.

129

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Seward R. Smith

(Residence in Baltimore: No. 640 N. Carey St. St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	single

6-DATE OF BIRTH. January 7, 1877
(Month) (Day) (Year)

7-AGE. 46 yrs. 4 mos. 24 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Renenue Officer
(b) General nature of industry, business, or establishment in which employed (or employer): U.S.Gov.

9-BIRTHPLACE, (State or Country). Maryland. Anne Arundel Co.

PARENTS.

10-NAME OF FATHER. Joseph B Smith

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Maryette R. Graham

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph B. Smith

(Address) 640 N. Carey St.

15-

JAN 2-1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 1/23
(Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) ....yrs. ....mos. ....ds.

(Signed) J S Haller M. D.
(Coroner)

6/2/23 192.. (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Olivet Cem	6-4 1923
UNDERTAKER.	ADDRESS
Geo. J. Smith	1532 Hollins St

NOTICE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D76316

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76316

CERTIFICATE OF DEATH.

X 137

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula Gressett

(a) RESIDENCE NO. 310 York Road, Towson, Md. ST. WARD Towson Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 15 - 18[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John D. Gress[illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Virginia Wms[illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Irvin D. Gressett

(Address) 605 Joppa Road

15 Filed Robert F. Harrison

Registrar

2-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 1 - 1923

17 I HEREBY CERTIFY, That I attended deceased from 5-28-, 1923, to 6-1-, 1923,

that I last saw her alive on 6-1-, 1923,

and that death occurred, on the date stated above, at 3:10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma, 1 year duration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6-1-23

Was there an autopsy? Partial

What test confirmed diagnosis? Clinical & P.M. findings

(Signed) H. J. Parr, M. D.

, 1923 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL June 4, 1923

20 UNDERTAKER F. A. Krause & Son

ADDRESS 703 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76317

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D76317

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp'l ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward C. Frosburg

(a) RESIDENCE NO. 424 N Belnord Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

INK—WRITE PLAINLY, WITH UNFADING INK—THIS

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced) HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Apr 22. 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Chas Frosburg

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Holland

12 MAIDEN NAME OF MOTHER Mary Poether

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Marie Frosburg
(Address) 424 N Belnord

15 Filed JUN 2 1923, 19 Robert P. Harrison
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1923

17

I HEREBY CERTIFY, That I attended deceased from May 29, 1923, to June 1, 1923, that I last saw him alive on June 1, 1923, and that death occurred, on the date stated above, at 10:0 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? P. S. & E.

(Signed) John J. Kirgan M. D.

, 19 (Address) St. Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem — DATE OF BURIAL June 5 1923

20 UNDERTAKER John Ellicott — ADDRESS [illegible]

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76318

CERTIFICATE OF DEATH.

113 D76318

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 N Washington ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E Quade

(a) RESIDENCE No. 215 N Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) February 10 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	21	

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Francis J Quade

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emma Horgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Francis Quade

(Address) 215 N Washington St

15 Filed JUN 2 1923 19 Robert F. Herbert Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1923

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1923, to June 1, 1923, that I last saw him alive on June 1, 1923, and that death occurred, on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:

Burns - Entrails & Delirium

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Leoff M. D.

6/2, 1923 (Address) 413 N Washington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem

DATE OF BURIAL June 2 1923

20 UNDERTAKER John Ulrich

ADDRESS 2007 Eutaw

U. S. WHITE, WRITE ENTRIES IN THIS STATEMENT, WITH UNFADING INK. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of C TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76319

CERTIFICATE OF DEATH.

31 D76319

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST., 14 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Stapney

(a) RESIDENCE NO. 542 McMechan st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Stapney

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Amelia Butler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant: Hospital Records

(Address) M.T.H.

15 Filed 2-1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1923, to May 31, 1923,

that I last saw him alive on May 31, 1923,

and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dasaglucca, M. D.

6-1-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 1 1923
20 UNDERTAKER James H. Daniels & Sons	ADDRESS 303

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76320

CERTIFICATE OF DEATH.

14-001 D76320

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2136 Division St. 14 WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles W. Purvey

(Residence in Baltimore: No. 2136 Division St.; 18 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May (Month) ..... (Day), 1854 (Year)

7-AGE, 69 yrs. ..... mos. 20 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), not known

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country). not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David A Howard

(Address) 592 Baker St.

15-

Filed ..... Robert P. Garrison ..... Registrar.

6-2-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, May (Month) 30 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 28 1923, to May 30 1923, that I saw him alive on May 29 1923, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. E. Daughaday M. D.

May 30, 1923 (Address) 16 E Lexington Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Greenmount | DATE OF BURIAL, June 2 1923

20-UNDERTAKER James A. Deems | ADDRESS 307 Greenmount

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76321 X 8 D76321

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 917 E. 30th St. ST., 9 WARD)

2-FULL NAME Clarence Emory Wilson Jr

(a) RESIDENCE NO. 917 E. 30th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year): April 8th 1916

7 AGE: Years 7 Months 1 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Wilmington Del.

PARENTS

10 NAME OF FATHER: Clarence E. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Princeton Va.

12 MAIDEN NAME OF MOTHER: Edith P. Burton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Fullerton Md.

14 Informant (Address): Clarence E. Wilson Fullerton Md.

15 Filed 19 Registrar: Robert P. Harrison

JUN 2-1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): June 10th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 5th, 1923, to June 10th, 1923.

that I last saw h— alive on June 10th, 1923,

and that death occurred, on the date stated above, at 3.40 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Septicemia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Scarlet Fever (duration) yrs. mos. 27 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. Lee Ayre M. D.

6/10/23 (Address) 1401 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Waugh Cemetery DATE OF BURIAL: June 13 1923

20 UNDERTAKER: Fred Lessenbee & Son ADDRESS: Fullerton

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D76322 HEALTH DEPARTMENT—CITY OF BALTIMORE 903 D76322

CERTIFICATE OF DEATH. 8 188

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Moulden

(Residence in Baltimore: No. 1734 Townsend Place St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	single

6-DATE OF BIRTH. March 18/1918 (Month) (Day) (Year)

7-AGE. 5 yrs. 2 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Chas. Moulden

11-BIRTHPLACE OF FATHER, (State or Country). Washington D.C.

12-MAIDEN NAME OF MOTHER. Elizabeth Plock

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Moulden

(Address) 1734 ownsehd Pl.

15- Filed JUN 2 - 1923 192.. Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. May 30/23 (Month) (Day) (Year) 192..

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.. Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock- Abdominal Hemorrhage-
Run over by automobile-pelvis crushed- accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J S O'Neill M. D. (Coroner)

6/2/23 192.. (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of InJury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cemetery DATE OF BURIAL. June 2 1923

20-UNDERTAKER. Kreamer Cook ADDRESS 502 E North

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 1923 D76323

94 D76323

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Rustee

(a) RESIDENCE NO. 733 N. Eden St. City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 17 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
		8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Ernest Rustee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Jeannette Pollard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Johns Hopkins Hospital Records

2-1923 ed . 19 Robert F. [illegible] Registrar

Asst. Local Health Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1923

17 I HEREBY CERTIFY, That I attended deceased from May 29 . 19 23 to May 31 . 19 23

that I last saw him alive on May 31 . 19 23

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Status lymphaticus.

(duration) yrs. 8 mos 19 ds.

CONTRIBUTORY (Secondary) Rickets and Tetany

(duration) 0 yrs. 2 mos. 0 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Post mortem examination

(Signed) William H. Sage Chamberlain M. D.

. 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Laurel Cemetery — DATE OF BURIAL Jun 2 1923

20 UNDERTAKER Mrs Robert A Elliott — ADDRESS 1775 Pennsylvania Ave

N.B. WHITE BLANKS (PRINTED) ONLY TO BE FILLED IN. AGE should be carefully supplied. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76324

CERTIFICATE OF DEATH.

90 D76324

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 2023 Druid Hill Av ST.; 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ambrose E Briscoe

(Residence in Baltimore: No. 2023 Druid Hill Av St.; 30 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Dec 29, 1863
(Month) (Day) (Year)

7-AGE, 59 yrs. 5 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Barber
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), California

PARENTS.

10-NAME OF FATHER, Erastus Briscoe

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eugenia Briscoe

(Address) 2023 Druid Hill Av.

15- Robert P. Heatwole
Filed 6-2-1923 ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 2, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 6 1923, to June 2 1923, that I saw h alive on June 1 1923, and that death occurred, on the date stated above, at 2A m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H S M Card M. D.

6/2, 1923 (Address) 2005 Druid Hill Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, George H. Holland DATE OF BURIAL, June 6, 1923

20-UNDERTAKER Cathedral Un ADDRESS 1631 Druid Hill Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Remarks Don't Know any other cause

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76325

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-D76325

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 W. Pratt St. 19 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melva F. Norman

(a) RESIDENCE. No. 1625 W. Pratt St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 7-1923

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Leroy C. Norman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emily H. Gibbons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Leroy C. Norman
(Address) 1625 W Pratt St

15 Filed JUN 2-1923 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1923, to June 1st 1923, that I last saw her alive on June 1st, 1923, and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia -

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duratiun) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? / Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) A Hellen Hemming M. D.

6/2, 1923 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 2 1923
20 UNDERTAKER	ADDRESS
Geo. L. Schmidt.	1101 Edmondson Ave.

INSTRUCTIONS TO PHYSICIANS AND UNDERTAKERS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Bks.

24 hours regulation waived
J. Frederick Pumpel
Asst. Com.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76326

CERTIFICATE OF DEATH.

D76326

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 Montpelier ST., 9 WARD)

2-FULL NAME Joan Joner

(a) RESIDENCE No. 609 Montpelier ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 5- 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	2	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Walter J. Joner

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Angie R. Jones

13 BIRTHPLACE OF MOTHER (city or town) Mass.
(State or country)

14 Informant Alex. Joner
(Address) 1909 E. Chase St.

15 JUN 2-1923 Robert P. Merriken
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1923

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1923, to June 2, 1923, that I last saw h[illegible] alive on June 1, 1923, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Purpura Haemorrhagica

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) Measles ?

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Chas. C. Conner M. D.

6/2, 1923 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	June 4 1923
20 UNDERTAKER	ADDRESS
F. J. Henson	1006 A. Lafayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76327

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76327

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. #1- Kennedy Ave ST., 4 WARD) Mr. Gorsuch ave

2-FULL NAME Frank Dietz

(a) RESIDENCE NO. #1- Kennedy Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widowed

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Ellen Dietz

6 DATE OF BIRTH (month, day, and year) 5/28/1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	0	4	~~hrs. min.~~

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paperhanger.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Dietz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Pouter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Dietz
(Address) #1- Kennedy ave

15 Filed JUN 2 1923 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1923

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1923, to June 1, 1923, that I last saw h— alive on June 1, 1923, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Face & Lungs

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Right Physical

(Signed) Wash G Towsa M. D.

(Address) 1224 E Cold Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Calvary Cem

DATE OF BURIAL 6/4 1923

20 UNDERTAKER George J Ruth

ADDRESS 1735 Harford Ave

AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76328

CERTIFICATE OF DEATH.

46 D76328

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1966 Paterson Park Ave ST., 8 WARD)

2-FULL NAME Mary - W. Road

(a) RESIDENCE NO. 1966 Paterson Park Ave ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James - H. Road.

6 DATE OF BIRTH (month, day, and year) April 26/1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Hohman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany Germany.

12 MAIDEN NAME OF MOTHER E. H. Hohman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant James - H. Road. (Address) 1930 Paterson Park Ave

15 JUN 2 1923 19 Robert P. Harrison; Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 10 1923 to May 30 1923, that I last saw her alive on May 30 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of about 2 yrs ago

Was there an autopsy? not

What test confirmed diagnosis? Microscope

(Signed) S. H. Magness M. D.

6/1 1923 (Address) 1206 Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 6/4 1923

20 UNDERTAKER George J. Ruth — ADDRESS 1735 Halford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76329

CERTIFICATE OF DEATH.

88 D76329

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 631 Pierce St. ST., 17 WARD)

2-FULL NAME Odessa Butler

(a) RESIDENCE NO. 631 Pierce St. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Living

6 DATE OF BIRTH (month, day, and year) July 31 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
~~34~~	34	11	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER Alfred Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER May Clarke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant May Clarke
(Address) 631 Pierce St

15 Filed JUN 2-1923 192... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) ... yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D. (Coroner.)

June 2 1923 (Address) 117 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	June 4 1923

20 UNDERTAKER Wm H. Chase & Son ADDRESS 1400 Mosher

Buried Lamit Clark

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76330

CERTIFICATE OF DEATH.

100-01 D76330

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 Whatcoat ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma Elizabeth Green

(a) RESIDENCE NO. 1114 Whatcoat ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 16/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Robert Green

11 BIRTHPLACE OF FATHER (city or town) A-A Co
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elsie Alcorn

13 BIRTHPLACE OF MOTHER (city or town) A-A Co
(State or country) Md

14 Informant Robert Green
(Address) 1114 Whatcoat St

15 [illegible] 19 Registrar

Robert F. Bearden

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1923

17

I HEREBY CERTIFY, That I attended deceased from May 28, 1923, to May 31, 1923, that I last saw her alive on May 31, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Primary)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. William Frey, M. D.

6/1, 1923 (Address) 924 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	June 3 1923
20 UNDERTAKER	ADDRESS
Wm. H. Chase & Son	1400 Mosher

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

A 2 — 1924

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76331

D76331

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 S. Bethel ST., V WARD)

2-FULL NAME Alexander Piaskowski

(a) RESIDENCE NO. 711 S. Bethel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Walter Piaskowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Josephine Liksarda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pol Austria

14 Informant Walter Piaskowski (Address) 711 S Bethel

15 JUN 2-1923 Robt. P. Herdman Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1923

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to June 2, 1923, that I last saw him alive on June 2, 1923, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Measles

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? / Date of /

Was there an autopsy? no

What test confirmed diagnosis? /

(Signed) John H. Rehberger M. D.

, 19 (Address) 1709 Aliceanna St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL 6-3 1923

20 UNDERTAKER John M. Weber

ADDRESS 1803 Bank St

WRITE plainly with pen and ink. AGE should be carefully supplied. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76332

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76332

CERTIFICATE OF DEATH.

7H-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 1312 Riggs Ave St. 16 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Maggie Gordy

(Residence in Baltimore: No. 1312 Riggs Ave. St.; yrs. 43 mos. 7 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Colored	

6-DATE OF BIRTH. Nov. 4 1879
(Month) (Day) (Year)

7-AGE. 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Home Duties
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Md.

PARENTS.

10-NAME OF FATHER. John Gordy.

11-BIRTHPLACE OF FATHER. (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Louisa Brum

13-BIRTHPLACE OF MOTHER. (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jeanette Gross

(Address) 5 S Roberts St.

15-

Filed JUN 3 - 1923 192.. G G Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 1 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration)..... yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (Duration)..... yrs. mos. ds.

(Signed) ..... M. D.
(Coroner)

..... 192.. (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Patuxent Cemetery DATE OF BURIAL. June 3 1923

20-UNDERTAKER. Wm. H. Chase & Son ADDRESS 1401 Mosher

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D76333

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76333

CERTIFICATE OF DEATH.

159-002

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 532 Gold St. ST. 15 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clorese Lewis

(Residence in Baltimore: No. 532 Gold St. St.; yrs., mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colored	Single

6-DATE OF BIRTH, June 3, 1923
(Month) (Day) (Year)

7-AGE, ...yrs.....mos.....ds. If LESS than 1 day, 13 hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Presley Lewis

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Ethel Gordon

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ethel Lewis

(Address) 532 Gold St.

15-

Filed JUN 3 - 1923, 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 3, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.
The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.
(Coroner.)

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Zion	June 6th, 1923
20-UNDERTAKER	ADDRESS
Joseph A Harrell	2318 Druid Hill

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76334

CERTIFICATE OF DEATH.

101-001

D76334

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 S. EUTAW ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME MARY KARALUS

(a) RESIDENCE NO. 218 SOUTH EUTAW ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of No

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66 ABOUT			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER Noknw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvanja

12 MAIDEN NAME OF MOTHER Noknw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant Luis Karalus
(Address) 218 S Eutaw Street

15 Filed JUN 3-1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1923

17 I HEREBY CERTIFY, That I attended deceased from May 28. 1923. to June 1. 1923.
that I last saw her alive on May 31. 1923.
and that death occurred, on the date stated above, at 9 am.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. D. Trilisnya M.D.

6/2, 1923 (Address) 682 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 4th 1923
20 UNDERTAKER	ADDRESS
John Grebliauckas	425 S Paca St

N. B.—WRITE PLAINLY, WITH CARBON INK. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

(DeJulio)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76335

CERTIFICATE OF DEATH.

118-001 D76335

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 S. Fremont ST.; 22 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincenzo De Julio

(Residence in Baltimore: No. 231 S. Fremont st St.; 3 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, December 24, 1857
(Month) (Day) (Year)

7-AGE, 66 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work, tailor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Lorenzo De Julio

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Benedetta

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)...Jaine De Julio.....

(Address)...231 S Fremont Ave.....

15- GC

Filed JUN 3 - 1923 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 1st, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 28 1923, to June 1st 1923, that I saw h[im] alive on June 1st 1923, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Volvulus

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Hernia of the abdominal wall

(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) Charles Testa M. D.

....., 191... (Address) 210 East st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer — DATE OF BURIAL, June 4th, 1923

20-UNDERTAKER John Grebliauckas — ADDRESS 425 S Paca St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D76336

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D76336

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. City Jail St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles ~~Jordan~~ Handy

(Residence in Baltimore: No. ~~###~~ 900 block Jordan St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col'd

5-Single, Married, Widowed, or Divorced. (Write the word.): ~~Married~~ U.K. Widowed

6-DATE OF BIRTH: Unknown (Month) (Day) (Year)

7-AGE: 44 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lab'r
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or Country): Baltimore

PARENTS

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (State or Country):

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address)

15- JUN 3 - 1923 192 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: May 30 (Month) (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Probably Suppurative Pneumonia (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

May 31, 192 3 (Address) 163 [illegible]

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death 3 days yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Not Known DATE OF BURIAL: June 3rd 1923

20-UNDERTAKER: Joseph A Farrell ADDRESS: 2319 Druid

Spec—12-23-21—E.B.R.S.—400 Bks.

D76337

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76337

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH Mercy Hospital

Registered No.

City of BALTIMORE: (No. St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Welcher

(a) Residence No. 2107 W. Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 16 1854

7-AGE, 69 yrs. 2 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Md.

PARENTS.

10-NAME OF FATHER, Michael Hogan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Eliz Thompson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Mrs. Wm. J. Huesman

(Address) 2107 W. Fayette St.

15- JUN 3 - 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 2 '23

17 I HEREBY CERTIFY, That I attended deceased from May 20 1923 to June 1923

that I last saw h[illegible]ative on June 1 1923

and that death occurred, on the date stated above, at 4.10 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency Cardiac failure

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bright's Disease

(Signed) D. J. Hagan M. D.

, 19 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem — DATE OF BURIAL, June 5 1923

20-UNDERTAKER, Wm J. Hartwell — ADDRESS 1136 W. Baltimore St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D76338 HEALTH DEPARTMENT—CITY OF BALTIMORE D76338

CERTIFICATE OF DEATH. 164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 W. Biddle. ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hugh Brady.

(a) RESIDENCE NO. 212 W. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January — 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Contractor.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Hugh Brady.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Bridget Simmons

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Margaret Ann Brady (Address) 212 W. Biddle St.

15 Filed JUN 3 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1923, to May 31, 1923, that I last saw h[illegible] alive on May 31, 1923, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Asthenia Senilis

Slowly failing for past year

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Ey hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robert W. Meffen, M. D.

June 3, 1923 (Address) 1076 Mad Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery DATE OF BURIAL June 4" 1923

20 UNDERTAKER: Wm J. Hartwell. ADDRESS 2236 Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76339 HEALTH DEPARTMENT—CITY OF BALTIMORE D76339

CERTIFICATE OF DEATH. 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 422 Wilson Town St.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Wilson

(a) RESIDENCE. NO. 422 Wilson Town St., 27 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. X mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Black	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jane A Wilson

6 DATE OF BIRTH (month, day, and year) Aug 11-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General labor work

(b) General nature of industry, business, or establishment in which employed (or employer) contractor of soil

(c) Name of employer Payne Balto. Co. Md

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md

PARENTS

10 NAME OF FATHER Abraham Wilson Town

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md

12 MAIDEN NAME OF MOTHER Cecilia Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Jane A Wilson
(Address) 422 Wilson Town Balto

15 Filed JUN 3-1923 19 G.G. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1-1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1922, to June 1, 1923.

that I last saw h em alive on May 31, 1923.

and that death occurred, on the date stated above, at 10.30 a m.

The CAUSE OF DEATH* was as follows:

Leuoma of stomach

(duration) X yrs. 7 mos. X ds.

CONTRIBUTORY (Secondary) General debility

(duration) X yrs. 3 mos. X ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? gross & microscopic

(Signed) W. H. Bergman, M. D.

, 19.. (Address) 6 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL June 3 1923

20 UNDERTAKER Hereford and Russell Edmondson Address Md

Spec.—6-9-19—H. P. Co.—1000 Blks.

D76340

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76340

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 420 N Chester St (St.) 6 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hyman Goldman

(a) RESIDENCE. NO. 420 N Chester St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rachie Goldman

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Goldman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rody Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis
(Address) 1439 E Balto St

15 Filed JUN 3 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-1 1923

17

I HEREBY CERTIFY, That I attended deceased from May 15 1923 to June 1 1923

that I last saw him alive on June 1 1923

and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Findings

(Signed) M. Finnerud, M. D.

6-2, 1923 (Address) 1001 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Hebrew Rem	June 3 1923

20 UNDERTAKER Jack Levis ADDRESS 1439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D76341

CERTIFICATE OF DEATH.

D76341 REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST.: Phipps Clinic WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Read A. McCaffrey

(Residence in Baltimore: No. 406 E 25th St.: 43 yrs., 6 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	married

6-DATE OF BIRTH. November (Month) 4th (Day), 1879 (Year)

7-AGE. 43 yrs. 6 mos. 27 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Lawyer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, J. W. McCaffrey

11-BIRTHPLACE OF FATHER (State or Country), Ohio

12-MAIDEN NAME OF MOTHER Mullen

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. P. Malloy Jr.

(Address) Johns Hopkins Hosp.

15- Filed JUN 3 1923 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 1st (Day), 1923. (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15 1923, to June 1st 1923, that I saw him alive on June 1st 1923, and that death occurred, on the date stated above, at 7.15 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral neoplasm

(Duration) ....yrs. 1 mos. ....ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) ....yrs. ....mos. 4 ds.

(Signed) James P. Malloy Jr. M. D.

June 3, 1923 (Address) Johns Hopkins Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 16 ds. In the State 43 yrs. 6 mos. 27 ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 406 E. 25th St.

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, 6/4 ....., 1923

20-UNDERTAKER Henry W. Kears & Son

ADDRESS 805 N. Calvert

I.C.D. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

Dr Sprunk 4902 Liberty Hgts

D76342 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 D76342

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4902 Liberty Heights St. 7th Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas M. Edes

(a) Residence No. 4902 Liberty Heights St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Sarah E. Edes

6-DATE OF BIRTH (month, day and year) April 10 - 1846

7-AGE, 77 yrs. ... mos. ... ds. | If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Constable City

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER James A Edes

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) Sarah E. Edes

(Address) 4902 Liberty Heights

15- Filed JUN 3 - 1923 19.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 2nd 1923

17- I HEREBY CERTIFY, That I attended deceased from May 12, 1923, to June 1st, 1923.

that I last saw him alive on June 1st, 1923

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

Secondary to Carcinoma of Sternum

(Duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Histological

(Signed) R. C. Leonard, M. D.

June 2nd, 1923 (Address) 4009 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. | DATE OF BURIAL, May 4 1923

20-UNDERTAKER Wm. Cook | ADDRESS 502 E North Ave.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76343 HEALTH DEPARTMENT—CITY OF BALTIMORE D76343

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 Hilliard St — ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William R. Johnson

(a) RESIDENCE NO. 1010 Hilliard St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marion R.

6 DATE OF BIRTH (month, day, and year): Oct 15 1846

7 AGE: Years 77; Months; Days; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: James H. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret Selby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Benjamin Johnson

(Address) 3112 Frankford Ave

15 JUN 3 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 2 1923

17

I HEREBY CERTIFY, That I attended deceased from July, 1922, to June 2, 1923,

that I last saw him alive on June 2, 1923,

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) W. D. Smith, M. D.

June 2, 1923. (Address) 107 W. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: June 5 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—EVERY item of information should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Patterson 829 N. Fulton Ave
1114 Hoad Ave

D76344

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76344

1-PLACE OF DEATH

City of BALTIMORE: (No. 222 Oak Mount Ave St. Carlton Ward) 5

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Elizabeth Daniel Gray

(a) Residence No. 222 Oak Mount Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, W

5-Single, Married, Widowed, Widow or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Gray

6-DATE OF BIRTH (month, day and year) Aug 2 1851

7-AGE, 71 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Nurse

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, John Gamble

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Susan Russell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14-

(Informant) Mrs. Walter Schreibel

(Address) 222 Oak Mount Ave

15-

JUN 3 - 1923 192

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 2 1923

17- I HEREBY CERTIFY, That I attended deceased from May 31 1923 to June 2 1923

that I last saw h[illegible] alive on May 31 1923

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(Duration) yrs. 1½ mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hemiplegia etc

(Signed) L. McCarthy, M. D.

June —, 1923 (Address) 114 Hoad Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL St. Johns Woodlawn, June 4, 1923

20-UNDERTAKER. Wm Cook ADDRESS 50 E. Lexington

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D76345

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76345

Registered No. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 1220 St. Paul St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Lytle

(a) Residence No. 1220 St. Paul St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline J. Lytle

6-DATE OF BIRTH (month, day and year) Aug 16 1841

7-AGE. 81 yrs. 9 mos. 17 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Harford Co (State or Country), Md

PARENTS.

10-NAME OF FATHER James Lytle

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Rachel Hopkins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Caroline J. Lytle

(Address) 1220 St. Paul St

15-

Filed JUN 3-1923 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 2-23

17- I HEREBY CERTIFY, That I attended deceased from March 21st, 1923, to June 2nd, 1923, that I last saw h.. alive on June 1st, 1923, and that death occurred, (on the date stated above, at 3.45 a.m.

The CAUSE OF DEATH* was as follows:

CHRONIC MYOCARDITIS

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) INFLUENZA

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thomas L. Shearer M. D

June 3rd, 1923 (Address) 905 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Green Mount DATE OF BURIAL, June 4 1923

20-UNDERTAKER, John C. Mitchell ADDRESS 1218 W. Fayette St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

1207 Eutaw
D76346

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1/4 -001 D76346

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3004 Evergreen Terrace ST. 13 WARD)

2-FULL NAME Susan Augusta Fraser Colton.

(a) RESIDENCE NO. 3004 Evergreen Terrace ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 ~~Single, Married~~, Widowed, or Divorced, ~~(write the word)~~ Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Wellington Colton.

6 DATE OF BIRTH (month, day, and year) June 12th 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Fraser

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Lindsay

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant (Address) Wellington Colton 3004 Evergreen Terrace

15 JUN 3-1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2nd 1923

17

I HEREBY CERTIFY, That I attended deceased from May 25, 1923, to June 2, 1923, that I last saw h alive on June 2, 1923, and that death occurred, on the date stated above, at 11:A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs — mos 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger, M. D.

(Address) 1207 Eutaw Place June 3, 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery. DATE OF BURIAL June 4 1923

20 UNDERTAKER J. Bertram Gore ADDRESS 1723 Eutaw Place

GE should be stated EXACTLY. PHYSICIANS should state
mation should be carefully supplied. AGE
at it may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Blks.

D76347

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D76347

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 E 33rd St., 9 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Georgie V Bray.

(a) RESIDENCE NO. 816 E 33rd St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry L Bray.

6 DATE OF BIRTH (month, day, and year) Apl 27-1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Hampton (State or country) Va

PARENTS

10 NAME OF FATHER Geo Holston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Elizabeth Jefferson

13 BIRTHPLACE OF MOTHER (city or town) Elizabeth City Co Va

14 Informant Mrs Harry L Bray (Address) 816 E 33rd St

15 Filed JUN 3-1923, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2-1923

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to June 2, 1923, that I last saw h W alive on June 1, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pharynx

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? 523 Shenda Ct

Did an operation precede death? No Date of . . .

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) S. A. Bishop, M. D.

(Address) 501 Shenda Ct

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemt. DATE OF BURIAL June 4 19 23

20 UNDERTAKER Peterson & Sons ADDRESS 1723 N Fay

N. B.—WRITE PLAINLY, with unfading ink. NAME should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76348

HEALTH DEPARTMENT--CITY OF BALTIMORE

D76348

CERTIFICATE OF DEATH

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 4230 Pinkerton Rd ST. 15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Lola May Johnson

(Residence in Baltimore: No. 4230 Pinkerton Rd St. — yrs. 4 mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 SINGLE, ~~MARRIED WIDOWED OR DIVORCED~~ (Write the word) Single

6 DATE OF BIRTH May 22 (Month) (Day), 1921 (Year)

7 AGE 2 yrs. 10 mos. — ds. If LESS than 1 day, — hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto Md

PARENTS

10 NAME OF FATHER Arthur C Johnson

11 BIRTHPLACE OF FATHER (State or country) Fredericksburg Va

12 MAIDEN NAME OF MOTHER Lola V. Hudson

13 BIRTHPLACE OF MOTHER (State or country) Balto Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur C Johnson

(Address) 4230 Pinkerton Rd

15 Filed JUN 3 - 1923 JUN 3 - 1923 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH June 2 (Month) (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13, 1923, to June 2, 1923, that I saw h— alive on June 1 & 2, 1923, and that death occurred, on the date stated above, at — m. The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) — yrs. — mos. 20 ds

Contributory (SECONDARY) Measles

(Duration) — yrs. — mos. 12 ds.

(Signed) John L Pennington M. D.

(Address) 1826 Bolton St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Woodlawn Cem | DATE OF BURIAL June 1923

20 UNDERTAKER Wm Lyon | ADDRESS 12 W Lanvale

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-26-44—M. & T.—2000 Bks.

D76349

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76349

38

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 734 W Mulberry ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Freeman

(Residence in Baltimore: No. 734 W. Mulberry St.; 85 yrs. 6 mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, ... (Month) Aug. (Day) 27, (Year) 1922

7-AGE, ... yrs. 5 mos. 6 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Walter Freeman

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER May Freeman

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessie Freeman

(Address) 734 W. mulberry St.

15-

Filed ....., 191.....

Registrar.

JUN 3 - 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. ..... (Month) June (Day) 2, (Year) 1923

17- I HEREBY CERTIFY, That I attended deceased from Jan 12 1923, to June 2 1923, that I saw h— alive on June 1 — 1923, and that death occurred, on the date stated above, at 1P, m.

The CAUSE OF DEATH* was as follows:

.....

..... Pneumonia Broncho

..... (Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Syphilis Congenital

..... (Duration) ..... yrs. 5 mos. 6 ds.

(Signed) C. Lincoln Jordan M. D.

June 2, 1923 (Address) 1017 N. Bond St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Farmer or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
W. Laurel Cem	6-4-1923
20-UNDERTAKER	ADDRESS
Daniel Carbon	Laurel

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76350 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76350

CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1334 W. North Ave. ST.: 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Henry Conway

(a) RESIDENCE. No. 1334 W. North Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary J. Conway

6 DATE OF BIRTH (month, day, and year): May 4th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79		28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter & Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Henry Conway

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Catherine Hedrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Elizabeth Downes. (Address): 1334 W. North Ave.

15 Filed JUN 3 - 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 1923

17 I HEREBY CERTIFY, That I attended deceased from October 31, 1922, to June 1, 1923, that I last saw him alive on June 1, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Right Left Hemiplegia.

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) (Coma) 2nd attack of Hemorrhage several days prior to death.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. C. Pole, M. D.

6-2-1923 Address) 203 E. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 4th 1923

20 UNDERTAKER: Wilbur W. Shiver ADDRESS: 1018 Edmondson Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76351

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 23 ✓ D76351

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A. Kelly Hospital 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ernestine Dodd

(a) RESIDENCE NO. Oklahoma City, Oklahoma

(Usual place of abode) ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred about 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A Henshaw Jr

6 DATE OF BIRTH (month, day, and year): June 29 1898

7 AGE: Years 24 Months 11 Days ✓ If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Florence Ala

PARENTS

10 NAME OF FATHER: Harry L. Dodd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Marie Warner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richland Ohio

14 Informant: Mrs. Harry L. Dodd (Address) Oklahoma city Oklahoma

15 JUN 3-1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3rd 1923

17

I HEREBY CERTIFY, That I attended deceased from May 4th, 1923, to June 3rd, 1923

that I last saw her alive on June 3rd, 1923,

and that death occurred, on the date stated above, at 10 3/4 a.m.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

CONTRIBUTORY (Secondary) (duration) Probably 6 weeks ? yrs. mos 3-4 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of May 7th 23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Guy U. Cromwell M. D.

6/3, 1923 (Address) 1415 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oklahoma city Oklahoma

DATE OF BURIAL: June 3 1923

20 UNDERTAKER: Chas. G. Black

ADDRESS: 742 Walnut ave

N. B.—WRITE PLAINLY, with permanent ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76352

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76352

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1016 N. Broadway ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME May R. Peters

(a) RESIDENCE NO. 1016 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis J. Peters

6 DATE OF BIRTH (month, day, and year) May, 31st, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Robert E. Lamb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Margt. Schoppler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Louis J. Peters

(Address) 1016 N. Broadway

15 JUN 3 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1st, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 11 1923 to June 1 1923

that I last saw her alive on June 1 1923

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 4 mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Clinical

(Signed) Carl McKinney M. D.

June 7 1923 (Address) 2224 E 39

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: 6/5/23 19

20 UNDERTAKER: Chas. F. Evans & Son, Inc. 118 W. — ADDRESS: Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D76353

CERTIFICATE OF DEATH

129 ✓

REGISTERED NO. D76353

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 2836 N.Calvert St.; WARD 17)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Maria L.Stewart

(Residence in Baltimore: No. 2836 N.Calvert St.; 73 yrs. 5 mos. 13 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: December 19, 1849 (Month) (Day) (Year)

7 AGE: 73 yrs. 5 mos. 19 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House-wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Thomas T.Hooper

11 BIRTHPLACE OF FATHER (State or country): Dorchester Co.Md.

12 MAIDEN NAME OF MOTHER: Eliza J.McNamara

13 BIRTHPLACE OF MOTHER (State or country): Dorchester Co.Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Paul H.Stewart (Son)

(Address) 2836 N.Calvert St.

15 JUN 3-1923

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June (Month) 1 (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1923, to June 1, 1923, that I saw h alive on June 1, 1923, and that death occurred, on the date stated above, at 4.05 P.M.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) 1 yrs. 3 mos. ds

Contributory (SECONDARY) Arteriosclerosis

(Duration) yrs. 6 mos. ds.

(Signed) John A Ehrman, M. D.

June 1, 1923 (Address) 1014 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park Cemetery — DATE OF BURIAL: June 4, 1923

20 UNDERTAKER: John A. Denny — ADDRESS: 715 Light St

Spec—12-23-21—E.B.R.S.—400 Blks.

D76354

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76354

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 129

City of BALTIMORE: (No. 1908 McHenry St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Stein

(a) Residence No. 1908 McHenry St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Michael Stein

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 71 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), New York

PARENTS

10-NAME OF FATHER, Zacharah Rhodes

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Sarah Bamott

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Minnie Stein

(Address) 1908 McHenry St.

15- JUN 3 - 1923 19?? Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 2—1923

I HEREBY CERTIFY, That I attended deceased from May 25 1923 to June 2 1923

that I last saw her alive on June 2 1923

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia (Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) R. C. Mottz M. D.

June 3 1923 (Address) 1903 W. Monument

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Bait. Hebrew Cem. DATE OF BURIAL: 6/4 1923

20-UNDERTAKER: Jahrens Co ADDRESS: 16 W Mad

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

76356

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76355

CERTIFICATE OF DEATH.

× 90 D76355

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hospital St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Nuzum

(Residence in Baltimore: No. Cairo, West Va. St.; yrs. ..... mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
male	white	Married

6-DATE OF BIRTH. ..... 1873 ..... 1 .....
(Month) (Day) (Year)

7-AGE. ..... 50 ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or .....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Salesman
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). unknown

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country). "

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Hopkins Hospital

(Address) .....

15- Filed JUN 4 - 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June 2/23 ....., 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insuffiency
(Arteriosclerosis, passive congestion, some scaring of heart autopsy at hospital)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Wallis M. D.
(Coroner)

6/3/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Cairo W. Va. DATE OF BURIAL. 6/3/23 19

20-UNDERTAKER. H. E. Hughes ADDRESS. Fort Bdr

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks. 76357

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76356 + 127 D76356

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Clarke

(a) Residence No. Greenbox, Md. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female — 4-COLOR OR RACE: White — 5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: John T. Clarke

6-DATE OF BIRTH (month, day and year): Oct 12, 1888

7-AGE. 34 yrs. 7 mos. 21 ds. — If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Queen Anne Co Md

PARENTS.
10-NAME OF FATHER: George Hill
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Delaware
12-MAIDEN NAME OF MOTHER: Emma Fairfellow
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Delaware

14- (Informant): Mercy Hospital Records
(Address):

15- Filed JUN 4 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 3rd 23

I HEREBY CERTIFY, That I attended deceased from May 29 1923 to June 3 1923

That I last saw her alive on June 3 19 23

And that death occurred, on the date stated above, at 12.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis
Peritonitis

(Duration) yrs. mos. 7 days

CONTRIBUTORY (Secondary) Pleurisy

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Hospital

Did an operation precede death? No Date of 5-29-23

Was there an autopsy? No

What test confirmed diagnosis? Dr. Lundy

(Signed) Dr. [illegible] M. D.

19 (Address) Mercy Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greensboro Md	June 4 19 23
20-UNDERTAKER Joseph B. Cook	ADDRESS 1003 W Balto St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

KODAK

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Cause of Peritonitis Unknown

Spec.—8-24-14—M. & T.—2000 Bks. 76355

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76357

CERTIFICATE OF DEATH.

X 90 D76357

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2126 E. Biddle ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James B Redmond

(Residence in Baltimore: No. 2126 E. Biddle St.; ..... yrs., ... mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) married

6-DATE OF BIRTH, ... Aug. (Month) 19 (Day), 1859 (Year)

7-AGE, 63 yrs. 9 mos. 12 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Clerk

9-BIRTHPLACE, (State or Country), Balto Co Md.

PARENTS.

10-NAME OF FATHER, John Redmond

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Catherine Campbell

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. Redmond

(Address) 923 6th Washington Ave

15- Filed JUN 4-1923, 191..... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June (Month) 1 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 27 1923, to June 1 1923, that I saw him alive on June 1, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

..... Aortic Regurgitation .....

.....

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... Hypertrophy .....

..... (Duration) ..... yrs. ..... mos. 9 ds.

(Signed) ..... J. Edward Illingsworth M. D.

June 2, 1923 (Address) 1613 N. Monroe St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Fairview Md. DATE OF BURIAL. June 4, 1923

20-UNDERTAKER W M Rowson ADDRESS 2238 N Howard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76358

CERTIFICATE OF DEATH.

31 D76358

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 N. Milton Ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Sophy McDonough

(a) RESIDENCE. No. 1319 N Milton Ave ST., 8 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Edward J McDonough

6 DATE OF BIRTH (month, day, and year) Sept 17 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
35	35	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Fittig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Cator

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edw J McDonough
(Address) 1319 N Milton Ave

15 Filed JUN 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1 1923 to June 1 1923, that I last saw her alive on June 1 1923, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) D F Herzog M D

June 1923 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	June 4 1923

20 UNDERTAKER John Zellers

ADDRESS 2008 Eden.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76359

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D76359

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bessemer Ave ST., 76 WARD)

2-FULL NAME Annie Scholl

(a) RESIDENCE NO. Bessemer Ave ST., Graudland Pk WARD
(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Conrad Scholl

6 DATE OF BIRTH (month, day, and year): Nov 23-1875

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
47	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Leopold Ramsel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Conrad Scholl
(Address): Bessemer Ave

15 Filed JUN 4-1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 1923

17

I HEREBY CERTIFY, That I attended deceased from May 29 1923 to June 1st 1923,

that I last saw her alive on June 1st 1923,

and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Do my knowledge

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Dod M. D.

19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: June 4 1923

20 UNDERTAKER: John Zellerick

ADDRESS: 2008 Bloom

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Brouchy

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76360 D76360

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hollins st. (St.) Mossaville 25 (Ward) 7

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph G. Brouchy

(a) RESIDENCE. No. Hollins st St. Mossaville Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 20/22

7 AGE — Years: — Months: 5 — Days: 13 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John Brouchy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mabel Carneal

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: John Brouchy
(Address): Mossaville Balto Md

15 Filed JUN 4 - 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1923

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1923 to June 3, 1923; that I last saw him alive on June 3, 1923; and that death occurred, on the date stated above, at 10.45 A m.

The CAUSE OF DEATH* was as follows: Measles

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon D Bozeg, M. D.
June 3 1923 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross — DATE OF BURIAL: June 4 1923

20 UNDERTAKER: Fred Crook Son — ADDRESS: 1406 Gilmor

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

B76361

CERTIFICATE OF DEATH.

90 B76361

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 Byrd ST., 24 WARD)

2-FULL NAME Peter Byrne

(a) RESIDENCE NO. 1706 Byrd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Ann Byrne

6 DATE OF BIRTH (month, day, and year): about 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	about 75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Anthony Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Andrew J. Byrne

(Address): 5116 Fort Garrison

15 Filed JUN 4 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 1923

17 I HEREBY CERTIFY, That I attended deceased from May 31 '23, 19 , to June 1 '23, 19 ,

that I last saw him alive on June 1 1923, 19 ,

and that death occurred, on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) H. B. Cole, M. D.

June 2 '23 (Address) 1203 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	June 5, 19 23
20 UNDERTAKER	ADDRESS
Margaret A. Flynn	1922 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76362

45

CERTIFICATE OF DEATH.

D76362

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Campbell

(a) RESIDENCE NO. 188 W Fort Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) about 1883

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER John Campbell

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Rose Cain

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant Mrs. Mary Sheckels
(Address) 158 W Fort ave

15 JUN 4 - 1923 ROBERT N. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1923

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1923, to June 2, 1923, that I last saw him alive on June 1, 1923, and that death occurred, on the date stated above, at 2.45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of Colostomy May 26-23

Was there an autopsy? No

What test confirmed diagnosis? Operation & Clinical findings

(Signed) Chas. Wm. Stewart M. D.

6/2, 1923 (Address) 1738 E. 28th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	June 5 1923
20 UNDERTAKER Margaret S. Flynn	ADDRESS 1422 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76363

CERTIFICATE OF DEATH.

89 D76363

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2818 E Baltimore St. (St.) 6 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Sylvester Billjack

(a) RESIDENCE. No. 2818 E Baltimore St. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 6 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

10 NAME OF FATHER John F. Billjacks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rebecca Ann Buggas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Ada Johnson

(Address) 2818 E Baltimore St

15 Filed JUN 4 - 1923 19

ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1920. to May 31. 1923.

that I last saw h-im alive on May 31. 1923.

and that death occurred, on the date stated above, at 10. P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 3 yrs. mos. ds.

CONTRIBUTOEY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Howard C. Silver, M. D.

19 (Address) 3706 Liberty Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	June 4 1923

20 UNDERTAKER A E Stughes ADDRESS 424 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information is required to be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76364 ✓ 45 D76364

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Church Home + Infirmary

CITY OF BALTIMORE: (No. 6 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lottie Leinasz.

(a) RESIDENCE NO. Easton Maryland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. ✓ mos. 6 ds. How long in U. S., if of foreign birth? ✓ yrs. ✓ mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David C. Leinasz

6 DATE OF BIRTH (month, day, and year) June 25 - 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	44	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Easton Md.

PARENTS

10 NAME OF FATHER Franklin Ayres

11 BIRTHPLACE OF FATHER (city or town) (State or country) Easton Md

12 MAIDEN NAME OF MOTHER Georgiana Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Easton Md.

14 Informant David C. Leinasz (Address) Easton, Md

15 JUN 4 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1923

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1923, to June 3, 1923, that I last saw her alive on June 3, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Duodenum

(duration) Not known yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia One Day

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of June 2 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Keith G. Rice, M. D.

, 19 (Address) Church Home + Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton, Md.

DATE OF BURIAL 6/4/23

20 UNDERTAKER A E Hughes

ADDRESS 412 S Broadway

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D76365

CERTIFICATE OF DEATH.

D76365

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 S. Fremont av ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William C. Rogers

(a) RESIDENCE NO. 102 S. Fremont av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lillie Huston Rogers

6 DATE OF BIRTH (month, day, and year) Dec 8th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	62	5	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture Mover

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER John W Rogers

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Lillie Huston Rogers
(Address) 102 S Fremont av

15 JUN 4-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-2- 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to June 2, 1923, that I last saw him alive on June 2, 1923, and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Hemiplegia & Uremia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stafford Davis M. D.

, 19 (Address) 1227 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	June 5 19 23
20 UNDERTAKER	ADDRESS
John J Fields	1200 N Lovedale

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76366

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D76366

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1409 N. Pratt St. ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Mathews,

(a) RESIDENCE NO. 1409 N. Pratt St ST., WARD

(Usual place of abode)

(if non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 17 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 16, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	—	—	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER William Mathews

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Cora Frazer.

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant William Mathews (Address) 1409 N. Pratt St.

15 JUN 4-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2. 1923

17

I HEREBY CERTIFY, That I attended deceased from May 28, 1923, to June 2., 1923, that I last saw him alive on June 1, 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Primary) (duration) — yrs. 7 mos 5 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Thos. Jenkins, M. D.

6/7/23 (Address) 888 N. Loudon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL June 5 1923

20 UNDERTAKER John Fields — ADDRESS 1200 W. Lombard St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76367

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76367

CERTIFICATE OF DEATH.

47

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1015 Bush St St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Sallie B Dreer

(a) Residence No. 1015 Bush St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of William A Dreer

6-DATE OF BIRTH (month, day and year) July 10/1871

7-AGE, 51 yrs. 10 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Frederick Co Md

PARENTS.

10-NAME OF FATHER, John A Beard

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Harriet Hyle

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pennsylvania

14- (Informant) William A Dreer

(Address) 1015 Bush St

15- Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

JUN 4-1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 2-1923

17- I HEREBY CERTIFY, That I attended deceased from Feb 3, 1923, to June 2, 1923.

that I last saw h e alive on May 27, 1923.

and that death occurred, on the date stated above, at 7.15 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthma

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D Maley Hoag M. D.

June 4. 1923 (Address) 1 E Lanvale. Balto

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cemetery

DATE OF BURIAL. June 5 1923

20-UNDERTAKER. Harry H Linwood

ADDRESS 4204 Ridgewood Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D76368

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D76368

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1213 W. Fayette ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Genevieve Auer

(a) RESIDENCE. No. 1213 W. Fayette ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? ✓ yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 6/1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER Wm. J. Auer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER Sarah Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Marys County. Md

14 Informant (Address) John E. Asper 3303 Walbrook Ave

15 Filed JUN 4-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 22, 1922 to June 3, 1923.

that I last saw her alive on June 2, 1923

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(Duration) Acute 10 mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No Physical Examination

What test confirmed diagnosis? ✓

(Signed) Henry C. Ohlig, M.D.

June 3 1923 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	June 6 1923

20 UNDERTAKER	ADDRESS
Harry J. Annacott	4204 Ridgewood Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76369

CERTIFICATE OF DEATH.

100-001 D76369

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 S. Wolfe ST.: 2 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Sokolowski

(a) RESIDENCE. No. 615 S. Wolfe ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 25-1921.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore.
(State or country) Md.

PARENTS

10 NAME OF FATHER Alexander Sokolowski.

11 BIRTHPLACE OF FATHER (city or town) Poland.
(State or country)

12 MAIDEN NAME OF MOTHER Anna Nistubitzy.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore.
(State or country) Md.

14 Informant Alexander Sokolowski.
(Address) 615 S. Wolfe St

15 Filed ..... 19 .....

JUN 4 - 1923 ROBERT R. KRAUTER, Registrar
Official Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1923

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1923, to June 3 - , 1923, that I last saw him alive on June 3, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Bronchitis. -

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic

(Signed) Philibert Antijuan, M. D.

, 19 (Address) 2442 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus. Cems	6/4 - 1923
20 UNDERTAKER	ADDRESS
M J. Sokowski.	405 S. Ann

GE should be stated EXACTLY. PHYSICIANS should state
mation should be carefully supplied. AGE sh
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

D76370

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76370

CERTIFICATE OF DEATH.

Registered No. C 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 4324 Brice St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George ~~Petri~~ Petri

(Residence in Baltimore: No. 4324 Brice St.; yrs. 65 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	widower

6-DATE OF BIRTH. March (Month) 26 (Day) 1858 (Year)

7-AGE. 65 yrs. 2 mos. 6 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer) ..... M.K.R.R. Co.

9-BIRTHPLACE. (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Charles Petri

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Theresa Mueller

13-BIRTHPLACE OF MOTHER. (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles H. Barron

(Address) 4324 Brice St

15- Filed JUN 4 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 2 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows: Endocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Inflamatory Rheumatism

(Duration) 4 yrs. mos. ds.

(Signed) James M. Fenton M. D. (Coroner)

June 2 1923. (Address) York Road

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, CREMATION. DATE OF BURIAL. June 5 1923

20-UNDERTAKER. ADDRESS. William Oak 502 E Madison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D76371
1-PLACE OF DEATH

CERTIFICATE OF DEATH. 113

D76371
Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hospital St., 24 Ward)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... SOPHIA BELLE FOSTER

(Residence in Baltimore: No. 1418 Reynolds St. St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	single

6-DATE OF BIRTH. Aug 25/23
(Month) (Day) (Year)

7-AGE. yrs. 9 mos. 7 ds. If LESS than 1 day, ...hrs. or.... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Lesley Foster

11-BIRTHPLACE OF FATHER, (State or Country). England

12-MAIDEN NAME OF MOTHER. Lillian R. Oliver

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lillian R. Foster
(Address) 1418 Reynolds St.

15. JUN 4 - 1923 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 2/23
(Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or Inquiry.) Inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Gastro-intestinal indigestion
Probably tozemia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....
(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. H. Dalton M. D.
(Coroner)
6/3/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Cedar Hill DATE OF BURIAL. June H 1923

20-UNDERTAKER. ADDRESS
Wm Leon for Edgar

Spec.—1-10-21—M&T—1500 Blks.

D76372

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 100-001 D76372

1-PLACE OF DEATH Home

CITY OF BALTIMORE: (No. 916 Mewington ave ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Ryan

(a) RESIDENCE NO. 916 Mewington ave ST., WARD 8th

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word)
M.	W.	Wife died

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Bettenmann

6 DATE OF BIRTH (month, day, and year) Dec 24 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ....min.
	76	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Cincinnati (State or country) Ohio

PARENTS

10 NAME OF FATHER Michael Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Julia Bettenmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant William Ryan (Address) 916 Mewington Ave

15 JUN 4 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 6 1923 to June 2nd 1923, that I last saw him alive on June 2nd 1923, and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Bronchus Hemorrhage

(duration) yrs. 2 mos . ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) William Drew, M. D.

19 (Address) 1742 Woodland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery | DATE OF BURIAL June 6 1923

20 UNDERTAKER Wm Cook | ADDRESS 503 E Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76373

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 | D76373

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Hillsdale Balto Co ST., 28 WARD)

2-FULL NAME James H Bryant.

(a) RESIDENCE NO. 106 Main ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Dorothy Bryant

6 DATE OF BIRTH (month, day, and year) Sept 16 1890

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
32	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer Penn R R

9 BIRTHPLACE (city or town) (State or country) Hillsdale Md

PARENTS

10 NAME OF FATHER Ransom T. Bryant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant (Address) Ransom T Bryant Hillsdale Md

15 Filed JUN 4 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2nd 1923

17

I HEREBY CERTIFY, That I attended deceased from May 25 1923 to June 2 1923.

that I last saw him alive on June 2nd 1923

and that death occurred, on the date stated above, at 7.25 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs and Throat

(duration) 1 yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) 1 yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? —— Date of ——

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Geo Y Eckhart, M. D.

19 (Address) Woodlawn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	June 19 23

20 UNDERTAKER Joseph B Cook ADDRESS 1003 N. Bal[illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D76374

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76374

161-001

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018 N. Payson. ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond Matters

(Residence in Baltimore: No. 1018 N. Payson St.; yrs. 4/12 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, April (Month) 21st (Day), 1923 (Year)

7-AGE, ...yrs. 1 mos. 12 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Chas. V. Matters

11-BIRTHPLACE OF FATHER (State or Country), Balt.

12-MAIDEN NAME OF MOTHER Daisy M. Brooks

13-BIRTHPLACE OF MOTHER (State or Country), France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Father- Chas V. Matters

(Address) 1018 N. Payson St.

15- Filed JUN 4-1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 3rd (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Apr 21st 1923, to June 2nd 1923, that I saw h[im] alive on June 2nd 1923, and that death occurred, on the date stated above, at 8 a.m.; m.

The CAUSE OF DEATH* was as follows:

Was found unconscious
Malnutrition

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Clement Evans M. D.

June 3rd, 1923 (Address) 833 N. Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. Is the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, June 4, 1923

20-UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Balto St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

(See Letter attached) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76375

57 D76375

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No.) Mercy Hospital St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie I. Foos.

(a) Residence No. 29 S Arlington Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 1 1875 1873

7-AGE 48 yrs. 4 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Music Teacher

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Charles Foos

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

OF MOTH[redacted] Fredk Rommel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Mr. H. Sullivan

(Address) 29 S. Arlington Ave.

15- Filed JUN 4 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 3 23

17- I HEREBY CERTIFY, That I attended deceased from May 20 19 23 to June 3 19 23

that I last saw h[redacted] alive on June 3 19 23

and that death occurred, on the date stated above, at 5 30 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Diabetic gangrene of foot & toes

(Duration) yrs. mos. 21 ds.

17-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sugar & Sugar

(Signed) J. [redacted] M.D.

6/4 1923 (Address) Mercy Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	June 6 1923
20-UNDERTAKER. Joseph B. Cook	ADDRESS 1003 N. Eutaw St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CONDUCTED BY THE SISTERS
CALVERT AND SARATOGA STREETS
Baltimore, Md.

June 4, 1923.

To whom it may concern

This is to certify that Howard Sullivan states Miss Lottie Foos was born Feb 1, 1873 instead of Feb 1, 1873 and the same change has been made on our records

Yours truly

Charles J. Foley M.D.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76376 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-00 D76376

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 3046 Cedar Ave. (Ward) 13

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Snell

(a) Residence No. 3046 Cedar Ave Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE. White

5-~~Single~~, Married, ~~Widowed or Divorced~~ (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or WIFE of) Samuel Snell

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Ireland

PARENTS

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14-INFORMANT Wm H Snell

(Address) 3046 Cedar Ave

15-Filed JUN 4 - 1923 19.. ROBERT R. KRAMER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 3 1923

17- I HEREBY CERTIFY, That I attended deceased from May 21 1923 to June 3 1923

that I last saw her alive on June 3 1923

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(Duration) 10 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis: Physical Signs

(Signed) Wm H Pearce M. D.

June 4. 1923 (Address) 2105 Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem. DATE OF BURIAL. June 5 19 23

20-UNDERTAKER: CHENOWETH & SON, ADDRESS 3617 CHESTNUT AVE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76377 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

161-001 D76377

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2719 Hampden ave 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Leonard Ridgley

(a) Residence No... 2719 Hampden St. ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 21 1923

7-AGE, yrs. mos. 14 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Infant

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), MD

PARENTS.

10-NAME OF FATHER, Earl Ridgley

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER, Myrtle George

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Baltimore

14-

(Informant) Earl Ridgley

(Address) 2719 Hampden ave

15-FILED JUN 4 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clark.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 4-23

17- I HEREBY CERTIFY, That I attended deceased from 5-21 1923 to June 4 1923

that I last saw him alive on June 3 1923

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Premature gestation

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Premature Labor

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) S. Hamburger M. D.

5-4 1923 (Address) 3701 Dolphin Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden DATE OF BURIAL: June 5, 1923

20-UNDERTAKER: GRENOWETH & SON, ADDRESS: 3617 CHESTNUT AVE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co. 1000 Bks.

D76378

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76378

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteer of America Hosp. ST.: Maternity WARD) 15

2-FULL NAME Boston Sebastian Fields Jr.

(a) RESIDENCE. NO. 1818 Warwick ave. ST.. WARD. 13 th

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 3 / 23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	hours 5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore md.

PARENTS

10 NAME OF FATHER Boston S. Fields Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bolts Md.

12 MAIDEN NAME OF MOTHER Glody Geraldine Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bolts.

14 Informant Mrs. Glodys S. Fields

(Address) 1818 Warwick Ave

15 Filed JUN 4 - 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1923

17

I HEREBY CERTIFY, That I attended deceased from June 3rd, 1923, to June 3rd, 1923, that I last saw him alive on June 3, [redacted], 1923, and that death occurred, on the date stated above, at 11 A[redacted] m.

The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Inspection

(Signed) Geo. E. Wells, M. D.

. 19 (Address) 1521 Edmondson Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Loudon Park June 4 1923

20 UNDERTAKER — ADDRESS

Sarah Dyer 1601 W Mar Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76379

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 129 D76379

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 943 Sterling St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred R. King

(a) Residence No. 943 Sterling St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 9 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Aug 23 1851

7-AGE, 71 yrs. 9 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work General Labor

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, James King

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), not known

14- (Informant) Mrs Lydia A. Willard

(Address) 943 Sterling St.

15- Filed JUN 4 - 1923 16- ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 2 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 14, 1921, to May 31, 1923, that I last saw him alive on May 31, 1923, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 20 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

6/3, 1923 (Address) 733 Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, June 4, 1923

20-UNDERTAKER, Edward W. Conklin ADDRESS 124 E Eager St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76380

CERTIFICATE OF DEATH.

109-002
109 D76380

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 23 WARD)

2-FULL NAME Mutton Gross -

(a) RESIDENCE NO. 210 N. Hamburg St - ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	1	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work (baby)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER John Gross -

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md -
(State or country)

14 Informant Susie Parks
(Address) 210 W Hamburg st

15 Filed JUN 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1923

17 I HEREBY CERTIFY, That I attended deceased from June 2 ....., 19 23 to June 3 , 19 23
that I last saw h alive on June 3 , 19 23
and that death occurred, on the date stated above, at 2.20 A. m.

The CAUSE OF DEATH* was as follows:
Retro pharyngeal abscess -

..... (duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 2 - 1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs -

(Signed) Leon Freedom - M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt auburn.

DATE OF BURIAL June 7-23

20 UNDERTAKER R. L. Partman

ADDRESS 902 Lindenhurst

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76381 11-001 D76381

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Johnson ST ST., 24 WARD)

2-FULL NAME George W Jory

(a) RESIDENCE NO. 1604 Johnson St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C Jory

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	#	#	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Wm M Jory

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Balto

12 MAIDEN NAME OF MOTHER Barbara Tracey

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Balto

14 Informant Mary F Jory
(Address) 1604 Johnson St

15 Filed JUN 4 - 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1923

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1923, to June 1, 1923, that I last saw h[illegible] alive on June 1, 1923, and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Robt Byrne, M. D.

6/ , 19 (Address) 1 E Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	6/5/23 19
20 UNDERTAKER J J Paley & Sons	ADDRESS 1716 Light St

WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76382

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76382

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 426 Pinkney St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Mary Kelly

(Residence in Baltimore: No. 426 Pinkney St. St. 70 yrs.... mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word): Widow

6-DATE OF BIRTH: — — 1853 (Month) (Day) (Year)

7-AGE: 70 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Work
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country): Ireland

PARENTS.

10-NAME OF FATHER: Pat Kelly

11-BIRTHPLACE OF FATHER, (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Lahey

(Address) 426 Pinkney St

15-

Filed JUN 4 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 2 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) 4 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Occlusion of Heart

(Duration) 1 yrs. ....mos. ....ds.

(Signed) James McNemar M. D. (Coroner)

June 4 1923 (Address) 70 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Cathedral DATE OF BURIAL: 6-5 1923

20-UNDERTAKER: J. F. Lahey & Son ADDRESS: 318 E Lexington St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10 2t—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D76383

CERTIFICATE OF DEATH.

+ 100-001

REGISTERED NO. D76383

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Christine A. Vitue

(a) RESIDENCE No. Sykesville, Md. R.F.D #1. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
		11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

PARENTS

10 NAME OF FATHER James Vitue

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Edna Reed.

13 BIRTHPLACE OF MOTHER (city or town) Concord. (State or country) Mass.

14 Informant C. A. Vitue

(Address) Sykesville, Md.

15 Filed JUN 4 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1923

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1923, to June 3, 1923, that I last saw her alive on June 3, 1923, and that death occurred, on the date stated above, at 4-30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. J. Fulton, M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakland, Md.	June 6 1923
20 UNDERTAKER	ADDRESS
Jno. R. Weer	Sykesville Md.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76384

CERTIFICATE OF DEATH.

90 D76384

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Geddes-

(a) RESIDENCE. No. Mt Hope Retreat ST. 28 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? 82 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single-

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher-

(b) General nature of industry, business, or establishment in which employed (or employer) School-

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles F. Geddes-

11 BIRTHPLACE OF FATHER (city or town) Huntly
(State or country) Scotland-

12 MAIDEN NAME OF MOTHER Mary A. A. McGuire

13 BIRTHPLACE OF MOTHER (city or town) Balto-
(State or country) Md-

14 Informant Records of Mt Hope Retreat
(Address) Baltimore

15 Filed JUN 4—1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1923

17

I HEREBY CERTIFY, That I attended deceased from Apr 10 1922, to June 4 1923,

that I last saw h[illegible] alive on June 4 1923,

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis - Cerebral Atheroma

Senile -

ans (duration) 5 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Senile Psychosis -

ABC (duration) 5 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md-

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery M. D.

. 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

New Cathedral Cemetery June 5 1923

20 UNDERTAKER STEWART & MOWEN COMPANY — ADDRESS 108 W. NORTH AVE.

(WILLIAM F. MOOREN, [illegible])

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bl. D76385

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

63076

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE (NO. ST., WARD)

REGISTERED NO. 174 001 D76385

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caleb Magruder

(a) RESIDENCE NO. 10 Francis ST., Annapolis Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 4 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 9 - 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk of Court

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

009

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Caleb C. Magruder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUN 4 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1923

17 I HEREBY CERTIFY, That I attended deceased from April 18th, 1923, to June 2nd, 1923, that I last saw him alive on June 2nd, 1923, and that death occurred, on the date stated above, at 2-30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency and Cerebral hemorrhage, the latter following an operation on April 26th, 1923 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Myocardial Disease) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 26/23

Was there an autopsy? Yes Autopsy

What test confirmed diagnosis?

(Signed) Winfield W. Scott, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bell, Emmanuel Ch. Md. DATE OF BURIAL June 5 1923

20 UNDERTAKER STERLING P. MOWEN COMPANY (WILLIAM T. WOODEN, Successor) ADDRESS 100 W. NORTH AVE

THIS IS A LEGAL RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Prostatectomy die. The patient had recovered & was doing well-until he was taken with a cerebral Hemorrhage

Spec.—1-10-21—M&T—1500 Blks.

D76386

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D76386

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 S. Chapel ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fredericka Zeiger

(a) RESIDENCE NO. 221 S. Chapel ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Otto Zeiger

6 DATE OF BIRTH (month, day, and year) Jan 3rd 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Dont Know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germ.

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germ.

14 Informant Otto H. Zeiger. (Address) 221 S. Chapel St.

15 Filed JUN 4 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31st 1923

17 I HEREBY CERTIFY, That I attended deceased from May 11th, 1923, to May 31st, 1923, that I last saw h alive on May 31st, 1923, and that death occurred, on the date stated above, at 2:15 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? X

(Signed) Chas. B. Kugler, M. D.

June 2, 19 (Address) 830 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz's Cemetery.	June 4 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	4038 Wolfe

N. B.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

KODAK

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76387

CERTIFICATE OF DEATH.

100-001 D76387

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1729 Fleet ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Merritt L. Straughen

(a) RESIDENCE NO. 1729 Fleet ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 27th 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER James L. Straughen

11 BIRTHPLACE OF FATHER (city or town) Rock Hall Md (State or country)

12 MAIDEN NAME OF MOTHER Annie T. Wenzel

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md (State or country)

14 Informant James L. Straughen (Address) 1729 Fleet St

15 Filed JUN 4 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2nd 1923

17

I HEREBY CERTIFY, That I attended deceased from May 31, 1923, to June 2, 1923, that I last saw h— alive on June 2, 1923 and that death occurred, on the date stated above, at 8:05 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? H

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Long, M. D.

(Address) 276 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	June 5th 1923

20 UNDERTAKER Lilly & Zeiler ADDRESS 4003 Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D76388

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D76388

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. 807 Parish alley ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Jordan

(Residence in Baltimore: No. 807 Parish alley . St.: yrs., 7 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M

4-COLOR OR RACE: Col'd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, August 14, 1922 (Month) (Day) (Year)

7-AGE, ...yrs. 9 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Jennison Dip

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Addie Jordan

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Addie Jordan

(Address) 807 Parish alley

15- Filed JUN 4 - 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 1, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ....(Inquest, autopsy or inquiry.) find that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows: Gastro-enteritis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) ....yrs. ....mos. ....ds.

(Signed) ....M. D. (Coroner.)

...., 191... (Address) ....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? ....

Former or usual residence ....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, June 4 19 23

20-UNDERTAKER Mrs Hazel A Claytor — ADDRESS 1225 Pennsylvania Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D76389

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 100-001

CERTIFICATE OF DEATH.

D76389

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1446 Morton ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Wales

(a) RESIDENCE NO. 1446 Morton ST., WARD 11

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Preston Walters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Florence Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Florence Jackson

(Address) 1446 Morton St

15 FILED JUN 4 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1923

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1923, to June 1, 1923, that I last saw her alive on June 1, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchitis & Cold

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. Hull, M. D.

, 19 (Address) 1426 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 4 1923
20 UNDERTAKER Mrs. R. A. Elliott	ADDRESS 1725 Eutaw

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D76390

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

32 D76390

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 Diller Ave. Gardenville St. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E. Knoedler

(Residence in Baltimore: No. 7 Diller Ave Gardenville St.; 9 yrs., 5 mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
Male	White	Sing[le]

6-DATE OF BIRTH, December 23rd, 1913 (Month) (Day) (Year)

7-AGE, 9 yrs. 5 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. md

PARENTS.

10-NAME OF FATHER, Joseph J. Knoedler

11-BIRTHPLACE OF FATHER (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER Dorothea S. Adelmann

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Joseph J. Knoedler

(Address) 7 Diller Ave.

15. Filed JUN 4 - 1923, 191.... ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 3, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1923 to June 3 1923, that I saw h[im] alive on June 3 1923, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Tuberculosis meningitis

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Pulmonary

..... (Duration).....yrs.....mos.....ds.

(Signed) C. Lowe Jarrett M. D.

June 3, 1923 (Address) 7 Diller Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE. (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery DATE OF BURIAL, June 6, 1923

20-UNDERTAKER Henry Hoeck Sons ADDRESS 301 E Eager St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec–12-23-21–E.B.R.S.–400 Bks.

D76391 HEALTH DEPARTMENT—CITY OF BALTIMORE D76391

CERTIFICATE OF DEATH.

2 74-001

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Willey

(a) Residence No. 2037 E. Pratt St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	?

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1866

7-AGE. 56 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), York, Pa.

PARENTS.

10-NAME OF FATHER, Nick Willey

11-BIRTHPLACE OF FATHER (city or town) (State or Country), York, Pa.

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), York, Pa.

14- (Informant) Municipal Hospital Record

(Address) UNIVERSITY OF MARYLAND

15- Filed ....., 192.. Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 31, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 31, 1923 to May 31, 1923 that I last saw him alive on May 31, 1923 and that death occurred, on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Hypertension

Asphyxia

(Duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Terminal) (Duration) ..... yrs. ..... mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McPowell M. D.

6/1/ 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, ... 19....
20-UNDERTAKER,	ADDRESS

JUN 4 - 1923

Burial Permit Clerk.

JUN 4 - 1923

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76392

CERTIFICATE OF DEATH.

5 1 D76392

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 Ensor st ST.; 10 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jack Glorioso

(Residence in Baltimore: No. 512 Ensor st St.; 2 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	white	

6-DATE OF BIRTH, Oct. (Month) 16 (Day), 1920 (Year)

7-AGE, 2 yrs. 7 mos. 17 ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Giovanni Glorioso

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER Concetta

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Giovanni Glorioso

(Address) 512 Ensor st

15- JUN 4 1923, Robert P. Harrison, 191..... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 3rd (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 30th 1923, to June 3rd 1923, that I saw him alive on June 3rd 1923, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

(a) Mitral regurgitation

(b) Endocarditis

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Rheumatism

(Duration) yrs. 1 mos. ds.

(Signed) Chas. Testa M. D.

....., 191... (Address) 210 Pearl st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St. Vincent Cem. | DATE OF BURIAL, June 4, 1923

20-UNDERTAKER George J. Ruth | ADDRESS 1735 Harford Ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76393

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76393

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1727 Mc Cabbin ST.: 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Wilmore

(a) RESIDENCE. No. 1727 Mc Cabbin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~ Widowed, or Divorced (write the word)
Female	col	Widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of Daniel Wilmore

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Ogo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Cornish

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Adline Pursley
(Address) 1727 Mc Cabbin

15 JUN 4-1923 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1923

17 I HEREBY CERTIFY, That I attended deceased from May 28 1923, to June 2, 1923, that I last saw h alive on June 2 1923, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
Natural Causes

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W Clyde Burns, M. D.

6-3-23 (Address) 2121 E Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 5 1923
20 UNDERTAKER	ADDRESS 1631
Edward Bryan	Orleans

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76394

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76394

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1712 Lemmon St. 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... Elizabeth Jones

(Residence in Baltimore: No. 1712 Lemmon St St.; yrs.... mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word) Single

6-DATE OF BIRTH. January (Month) 3 (Day) 1923 (Year)

7-AGE, 1 yrs. 5 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... do

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER, Bernard Jones

11-BIRTHPLACE OF FATHER, (State or Country) Charleston S C

12-MAIDEN NAME OF MOTHER, Elva Shutt

13-BIRTHPLACE OF MOTHER, (State or Country) Gardiner Me

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Elsie Jones

(Address) 1712 Lemmon St

15- Robert P. Harrison

JAN 4-1923 192.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, January (Month) 3 (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said decedent came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Measles

(Duration) ....yrs. ....mos. 4 ds.

CONTRIBUTORY (Secondary) Lack of attention

Medical (Duration) ....yrs. mos. 6 ds.

(Signed) James W. Fenton M. D. (Coroner)

Jan 4 1923 (Address) 700 E Lanvale

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Western Cem	6-4- 1923
20-UNDERTAKER	ADDRESS
Burd Evans	916 Pa ave

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76395

D76395

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 185

CITY OF BALTIMORE: (No. 742½ W. Saratoga ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alvina Brazier

(a) RESIDENCE. No. 742½ W. Saratoga ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Late Geo. W. Brazier

6 DATE OF BIRTH (month, day, and year) 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Alexander Sumwalt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known

14 Informant: Walter R. Brazier

(Address) 742½ W. Saratoga St.

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

4-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1923

17

I HEREBY CERTIFY, That I attended deceased from May 14, 1923, to June 2, 1923, that I last saw he alive on June 2, 1923, and that death occurred, on the date stated above, at 5.00 P m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Old plaque & Senile Accidental (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) V. Van Williams Jr., M. D.

, 19 (Address) 601 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 5 1923
20 UNDERTAKER	ADDRESS
William W. Shriver	1018 Edmondson Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76396

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D76396

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 331 E. Ellwood Ave ST., 1 WARD)

2-FULL NAME Sarah L. Beck,

(a) RESIDENCE No. 331 E. Ellwood Ave ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry R Beck

6 DATE OF BIRTH (month, day, and year) Nov. 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Queen Anne Co Md

PARENTS

10 NAME OF FATHER Henry Talley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Hambrooke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs L J Griffiths

(Address) 331 E Ellwood Ave

15 Filed , 19 Registrar

Robert P. Harrison;

c/o Mrs L J Griffiths Via Tolchester Steamboat Co

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1923

17

I HEREBY CERTIFY, That I attended deceased from May 31, 1923, to June 3, 1923, that I last saw h alive on June 3, 1923, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. LeRoy, M. D.

June 4, 1923 (Address) 1701 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Hall Md	June 5 1923
20 UNDERTAKER	ADDRESS
Wm Cook	502 E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

4-1923

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic Nephritis

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76397

CERTIFICATE OF DEATH.

100-001 D76397

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pinkney Mosley

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
60?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Mosley

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address)

15 Filed Robert P. Harrison Registrar

4-1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1923

17

I HEREBY CERTIFY, That I attended deceased from May 31, 1923, to June 2, 1923, that I last saw him alive on June 2, 1923, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Senile Dementia

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (Terminal) (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McPowell M. D.

, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ind Auburn Cem	6/4/23
20 UNDERTAKER	ADDRESS
Jas. R. Skinner	1625 C. Ind. st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76398

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76398

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Hospital ST., 27 WARD)

2-FULL NAME John O. Brewster

(a) RESIDENCE No. 1 Richmond ave, Hamilton ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Brewster

6 DATE OF BIRTH (month, day, and year) 6/19/1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer odd

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Moses Brewster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Hanna Mahr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Catherine Brewster
(Address) 2 Richmond Ave

15 JUN 4 1923 16 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 / 19

17 I HEREBY CERTIFY, That I attended deceased from 5/15, 1923, to 6/1, 1923, that I last saw him alive on 6/1, 1923 and that death occurred, on the date stated above, at 8:30 a m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis
Arteriosclerosis
Pneumonia fort,

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. & Physical findings

(Signed) N. J. Parr, M. D.

6/1, 1923 (Address) Franklin & Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem DATE OF BURIAL 6/5 1923

20 UNDERTAKER George J Ruth ADDRESS 1735 Hanford

WARNING—THIS BLANK WITH CONTENTS FILLED IN IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76399

CERTIFICATE OF DEATH.

155

D76399

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hosp. 9 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Meyers Jr

(a) RESIDENCE NO. 1512 Asquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year) 11 4 1919

7 AGE: Years 3 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): ——

(c) Name of employer: ——

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm G Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Edith Meyers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Wm G Meyers 1512 Asquith St

15 Robert P. Harrison, M. D. Registrar

Burial Permit Clerk.

JUN 4-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1923

17 I HEREBY CERTIFY, That I attended deceased from May 27. 1923. to June 3. 1923. that I last saw him alive on June 3 1923, and that death occurred, on the date stated above, at 6.50 A. m.

The CAUSE OF DEATH* was as follows:

Acute mastoiditis and Lateral Sinus Thrombosis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) General Septicaemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 5-30-23

Was there an autopsy? Not

What test confirmed diagnosis? S. & operation

(Signed) J. V. Pezzetti M. D.

. 19 (Address) St. Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: 6/5 1923

20 UNDERTAKER: J J Ruth

ADDRESS: 1135 Harford

B.—WRITE PLAINLY, WITH PENCIL OR INK. Every ... of information should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ... of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76400

CERTIFICATE OF DEATH.

47 / D76400

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 N. Calhoun ST.: 19 WARD)

2-FULL NAME Miss Mary L Rush,

(a) RESIDENCE. NO. 419 N Calhoun ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/14/1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER Chas F. Rush

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER Kunigunda Hahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Holland

14 Informant (Address): Joseph Rush 419 N Calhoun St

15 Filed 19

Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1—1923

17 I HEREBY CERTIFY, That I attended deceased from April-1-, 1922, to June 1—, 1923.

that I last saw her alive on June-1, 1923

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Right Breast with Ulceration

Lungs (duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Metastatic Carcinoma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Martin A Short, M. D.

6-2, 1923 (Address) 8064 Fullerton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: 6/5 1923

20 UNDERTAKER: George J Ruth

ADDRESS: 1735 Hurford Ave

JUN 4-1923

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

163 T 44
D 76401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-102 D76401

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 9 WARD)

2-FULL NAME Henry Corner

(a) RESIDENCE No. 72 E Wyndhurst Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced (or) WIFE of: HUSBAND of Henry Corner (Father).

6 DATE OF BIRTH (month, day and year): April 18, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	—	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Henry Corner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ellanor Riggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Keepers. Robert P. Harrison

15 JUN 4-1923, 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1923, to June 4, 1923, that I last saw him alive on June 4, 1923, and that death occurred, on the date stated above, at 10.00 A m.

The CAUSE OF DEATH* was as follows:

Congenital malformation of the heart

(duration) Life yrs. mos ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?...

(Signed) H H Mesch, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: June 5 19 23

20 UNDERTAKER: H E Kuhn

ADDRESS: 1100 N Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76402 D76402

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1626 E. Twenty Ninth ST.; 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick W Haake

(a) RESIDENCE. No. 1626 E. Twenty Ninth ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 11 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Bernard Haake

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt.

12 MAIDEN NAME OF MOTHER Anthena Schaub

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Bernard Haake
(Address) 1626 Twenty Ninth

15 Filed JUN 4-1923 19 Robert P. Herrington Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to June 4, 1923, that I last saw h in alive on June 3, 1923, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H P Herzog M D, M. D.

June 4/23 19 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 5 1923
20 UNDERTAKER	ADDRESS
Wendell D Appleton	573 Mun

Burial Permit Clerk.

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76403

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76403

CERTIFICATE OF DEATH.

11-002

6

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 411 N. Wolfe St. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Twamley

(Residence in Baltimore: No. 411 N. Wolfe St. St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write word.)
female	white	Widowed

6-DATE OF BIRTH. May 13/1852 (Month) (Day) (Year)

7-AGE. 71 yrs. mos. 21 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). New York

PARENTS.

10-NAME OF FATHER. Allen Vaseng

11-BIRTHPLACE OF FATHER, (State or Country). New York

12-MAIDEN NAME OF MOTHER. Susan Grant

13-BIRTHPLACE OF MOTHER, (State or Country). XXXXXXXX

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isaac Twamley

(Address) 411 N. Wolfe St.

15- 6-4-1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 4/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insuffiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. 6 mos. 28 ds.

(Signed) J. H. Cain M. D.
(Coroner.)

6/4/23 1923 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Lorraine Cem June 6 1923

20-UNDERTAKER. ADDRESS
William Ecal 502 E Nalt a

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

B-8947 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 40 D76404

CERTIFICATE OF DEATH. /

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hos. ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Sommerfield City

(a) RESIDENCE NO. 10 N. Spring St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	23	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Essie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Johns Hopkins Hospital Records

(Address)

15 Filed JUN 4 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1923

17

I HEREBY CERTIFY, That I attended deceased from May 25, 1923, to June 2, 1923, that I last saw her alive on June 2, 1923; and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Tub-ovarian abscess, right
Hemoperitoneum, ? cause
Secondary anemia.

OVER

(duration) — yrs. 2-3 mos — ds.

CONTRIBUTORY (Secondary) operation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of June 2-23

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Co. Md. DATE OF BURIAL June 5th 1923

20 UNDERTAKER Milton Davis ADDRESS 315 N Eden St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gonococcic Infection

Spec. 6-9-19—H. P. Co.—1000 Blks.

D76405

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76405

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 Reservoir St.: 13 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Stabler Jr.

(a) RESIDENCE. NO. 610 Reservoir ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Butler Stabler

6 DATE OF BIRTH (month, day, and year) Mch. 16/1836

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
87	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Edward Stabler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Deborah Pleasants

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Edward Alford Stabler (Address) Fern Hills

15 Filed JUN 5 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 16, 1923, to June 3, 1923, that I last saw him alive on June 3, 1923, and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 10+ yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary & Physical

(Signed) Austin T. Robertson M. D.

(Address) 1307 N. Charles St. 6/4 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friends Burial Ground	June 5th 1923

20 UNDERTAKER	ADDRESS
Chas. E. Franck	802 Madison Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76406 — 129 D76406

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter S. Moore

(a) RESIDENCE NO. 744 W. Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ht refused information

6 DATE OF BIRTH (month, day, and year) Unknown 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr George Holden

(Address) Dept. of Health

15 JUN 5 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-4 1923

17 I HEREBY CERTIFY, That I attended deceased from 5-3- , 1923 , to 6-4 , 1923 ,

that I last saw him alive on 6-4 , 1923

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

Cardiac dilation

Con. Int. nephritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Edema of Lungs

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. J. Dorsey, M. D.

6/4, 1923 (Address) Franklin Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	June 7 1923
20 UNDERTAKER	ADDRESS
Edw J. Conway	901 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

D76407

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

75-001 D76407

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 E. 20th ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Codori

(a) RESIDENCE NO. 511 E. 20th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Codori

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Bernard Cassidy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Charles Cassidy

(Address) 4263 Penton St

15 FILED JUN 5 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1921 to June 1923.

that I last saw her alive on June 3, 1923,

and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Signs & Symptoms

(Signed) Mary F. Boglem M. D.

6-4, 1923 (Address) 1028 Valley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL June 6 1923

20 UNDERTAKER H. C. Windfield — ADDRESS 914 Gramm

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76408

CERTIFICATE OF DEATH.

51 D76408

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Private Hospital ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary V. Burrell

(a) RESIDENCE No. 1631 Penna ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 13, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Moses H. Burrell

11 BIRTHPLACE OF FATHER (city or town) Linden (State or country) Va.

12 MAIDEN NAME OF MOTHER Jennie Thompson

13 BIRTHPLACE OF MOTHER (city or town) Louisa (State or country) Va

14 Informant Jennie Jones (Address) 1631 Penna ave

15 Filed JUN 5 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1923, to June 4, 1923, that I last saw her alive on June 4 —, 1923 and that death occurred, on the date stated above, at 12:20 P m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Acute Inflamatory Rheumatism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1631 Penna. ave

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) Marcellus E. Tong M. D.

, 19 (Address) 1445 N. Carey st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr. Brown — DATE OF BURIAL May 6th 1923.

20 UNDERTAKER Farmer & Dwight — ADDRESS 1644 Cary

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76409

CERTIFICATE OF DEATH.

182 D76409

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) off Broening Park. (ST.) Spring Gardens, (WARD) 21

2-FULL NAME John F. Reese.

(a) RESIDENCE NO. 400 W. Ostend St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? --- yrs. --- mos. --- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) February 19th. 1905.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	18	3	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Nat. Enaml. & Stmp. Co.

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Frederick Reese.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Martha M. Mielke.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Martha M. Reese, (mother)
(Address) 400 W. Ostend St.

15 FILED JUN 5 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd. 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.
Fall from a boat.
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

Jun 4th, 1923 (Address) 1017 St. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence ....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Brooklyn DATE OF BURIAL Jun 7 1923

UNDERTAKER William Cook ADDRESS 502 E. Balto.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Schaegge. 5 9K. 112 TKDonah

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76410

CERTIFICATE OF DEATH.

D76410

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 923. W. Franklin ST., 18 WARD)

2-FULL NAME Anna G. Schaegged.

(a) RESIDENCE NO. 923 W. Franklin ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Mar

5a If married, widowed, or divorced (or) WIFE of: Otto. Schaegged.

6 DATE OF BIRTH (month, day, and year): July 7 1874

7 AGE: Years 48. Months 10 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond Va

PARENTS

10 NAME OF FATHER: Levy. Levy

11 BIRTHPLACE OF FATHER (city or town) (State or country): England.

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Otto Schaegge (Address) 923 W Franklin Street

15 JUN 5 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3 1923

17 I HEREBY CERTIFY, that I attended deceased from June 3 1923 to June 3 1923.

that I last saw her alive on June 3 1923

and that death occurred, on the date stated above, at 10 [illegible] a m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

12 hrs (duration)

CONTRIBUTORY (Secondary) Heart failure

12 hrs (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? 923 W. Franklin

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) H. J. Frazer M. D.

6/4 1923 (Address) 1418 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: June 5 1923

20 UNDERTAKER: William Cook — ADDRESS: 532 E Balto

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D76411 HEALTH DEPARTMENT—CITY OF BALTIMORE D76411

CERTIFICATE OF DEATH.

1291

1-PLACE OF DEATH Hebrew Hospital REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3 ST., WARD)

2-FULL NAME Mare Meyers

(a) RESIDENCE NO. 124 S. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ethel Meyers

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 42; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Presser

(b) General nature of industry, business, or establishment in which employed (or employer): Tailoring

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: aba Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Sarah Meyers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 E Balto St

15 Filed JUN 5 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1923 to June 4, 1923, that I last saw him alive on June 4, 1923 and that death occurred, on the date stated above, at 10.45 a.m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Chr. nephritis

(duration) yrs. 3 mos (?) ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Blood, chemistry findings

(Signed) Isidor J. Fury M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mehrer Southern DATE OF BURIAL: June 5 1923

20 UNDERTAKER: Jack Lewis ADDRESS: 1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D76412

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-00 D76412

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 W. Lanvale ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Sheridan

(a) RESIDENCE NO. 702 W Lanvale ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Hasa Fletcher

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Mollie Sales b 4. 1923

13 BIRTHPLACE OF MOTHER (city or town) Balt (State or country)

14 Informant (Address) 702 W Lanvale St Gertrude Hall

15 Filed JUN 5 1923 ROBERT R. KRAUTER Registrar

Lucie Parrott Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1923, to June 3, 1923

that I last saw her alive on June 2, 1923,

and that death occurred, on the date stated above, at 6.30 A.m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Chronic Bright Disease

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Bright Disease & Complications Disease

(duration) yrs. 4 mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr L W Kennard M. D.

(Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	June 6 1923
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1735 Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76413

CERTIFICATE OF DEATH.

43 D76413

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital St., 19 WARD)

2-FULL NAME James E. Farrell.

(a) RESIDENCE NO. 20 N. Mount St. Balt WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Female~~ Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotte Farrell

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65 yrs.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Peter Farrell

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Egan

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mrs. Catherine Farrell
(Address) 20 N. Mount St.

15 Filed JUN 5 - 1923 ROBERT R. KRAUPER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd 1923

17

I HEREBY CERTIFY, That I attended deceased from May 30, 1923, to June 3, 1923, that I last saw him alive on June 3, 1923, and that death occurred, on the date stated above, at 8:00 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

Arteri-sclerosis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Head Palate.

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? yes Date of June 1.

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward A. Kitlowski, M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 6/6/23

20 UNDERTAKER Geo. C. Finley Fulton & Fayette

ADDRESS

N. B.—WRITE PLAINLY, with unfading ink. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Dorw.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D76414

D76414

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

2-FULL NAME Elizabeth Dorn

(a) RESIDENCE NO. Bay View Asylum ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Dorn
Cert. 76-1853

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....mln.
69	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER Justis Roth

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Ger.

12 MAIDEN NAME OF MOTHER Henderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Ger.

14 Informant Ida V. Pickett (Daughter)
(Address) 3575 E. Fairmount Ave

15 Filed JUN 5 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1923

17

I HEREBY CERTIFY, That I attended deceased from 4-12-23 19 , to June 3 , 1923.

that I last saw h alive on June 3, , 1923,

and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Senility

.....(duration) yrs. mos ,ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Terminal) .....(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McDonnell, M. D.

, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Lawn — DATE OF BURIAL June 5 1923

20 UNDERTAKER Lilly & Zeiler — ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76415

CERTIFICATE OF DEATH.

202 D76415

1-PLACE OF DEATH U.S. Industrial Chemical Co.

CITY OF BALTIMORE: (No. Fairfield. St., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernest G. Awiszus.

(a) RESIDENCE NO. 730 McCabe Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? 29 yrs. ---- mos. ---- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) March 9th. 1894.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	29	2	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Welder.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Electric Welding Co

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Samuel Awiszus,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant James C. Johnson. (Address) 730 McCabe Ave.

15 Filed JUN 5-1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4th. 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull. Struck in the face by the top of an exploding chemical drum. Accidental death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

Jun, 4th, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	June 5 1923
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

INSTRUCTIONS—AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76416

CERTIFICATE OF DEATH.

49

D76416

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Fairmount Ave E. ST.; 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Sloeum

(a) RESIDENCE. NO. 1424 Fairmount Ave ST.. WARD.
(Usual place of abode) all his life
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~WIFE of~~ Rose V Sloeum

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) Dr Bierman.
(c) Name of employer Hospital Baltimore Md

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John H. Sloeum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Maria A Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Albert D Sloeum
(Address) 404 Diamond St.

15 Filed JUN 5 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1923

17 I HEREBY CERTIFY, That I attended deceased from ~~28~~ May, 1923, to June 3, 1923,
that I last saw h alive on June 2, 1923
and that death occurred, on the date stated above, at 9.30 p.m.
The CAUSE OF DEATH* was as follows:
Sarcoma (?) of the right femur.
Unknown Duration

CONTRIBUTORY (Secondary) Forgetful & senile Senile. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto, Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Murray Field Boyle M. D.
(Address) 4 W. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	6/6 '23
20 UNDERTAKER Samuel H Kunsley	ADDRESS 512 Eddy

MAILED CARD, WITH ENDING INFORMATION, TO ALBERT D SLOEUM, 404 DIAMOND ST.

WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76417

CERTIFICATE OF DEATH.

113

D76417

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1003 Mc Culloh St. ST. 11 WARD)

(If death occurred in a hospital or Institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Booker

(Residence in Baltimore: No. 1003 Mc Culloh St. St.; yrs., / mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	colored	Single

6-DATE OF BIRTH, May 2, 1923.
(Month) (Day) (Year)

7-AGE, ...yrs. /..mos. ...ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... Domestic

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Joseph Booker

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Sarah Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sarah Booker

(Address) 1003 Mc Culloh St

15- Filed JUN 5-1923 191... ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 2, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.)
.....find that said deceased came to.....death on the day stated above.
The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.
(Coroner.)

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, June 7 1923

20-UNDERTAKER Samuel S. Hendley ADDRESS 1128 Edd

(See affadirit over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76418 — CERTIFICATE OF DEATH. — X 90 — D76418

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 127 W. 2d St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Ernest Stokes

(Residence in Baltimore: No. 127 W. 2d St.; yrs. ... mos. 5 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE. C

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. Unknown ....., 1..... (Month) (Day) (Year)

7-AGE. 14 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work. Labor (b) General nature of industry, business, or establishment in which employed (or employer). Odd Jobs

9-BIRTHPLACE, (State or Country). Va.

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). " Va.

12-MAIDEN NAME OF MOTHER. "

13-BIRTHPLACE OF MOTHER, (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Stokes

(Address) Elwood Co. Va

15-FILED JUN 5 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 1 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

1 year X

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) ..... M. D. (Coroner)

June 5 1923 (Address) 832 N. Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Virginia

19-PLACE OF BURIAL Woodbine Cem. Va. DATE OF BURIAL 6-5-23

20-UNDERTAKER Samuel Handy ADDRESS 1 Eddy St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

K • S • A • FEETY

On June 6th 1923 personally appeared before me
Mr Wm Stokes, the Son of Guest Stokes, who
Swears the name of Ernest Stokes is incorrec
the same should read Guest Stokes. on dea
Certificate # D 76418.

Sed Wm Stokes (Son

Allmond Co. Va.

~~Notary~~ Pubbe.

George H Gresh
Notary Pubbe

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D76419 HEALTH DEPARTMENT—CITY OF BALTIMORE D76419

94

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns HOpkins Hospital St. 17 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marshall Temple

(Residence in Baltimore: No. 534 St. Marys St. St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write word.)
male	black	Single

6-DATE OF BIRTH. May 12/1921 (Month) (Day) (Year)

7-AGE.				If LESS than 1 day,
2	yrs.	24	ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Harvey Temple

11-BIRTHPLACE OF FATHER. (State or Country). Ashland Va.

12-MAIDEN NAME OF MOTHER. Bessie Hughes /Perry/Terry/

13-BIRTHPLACE OF MOTHER. (State or Country). Baltomore Md. /Hanover Co/Va/

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harvey Temple

(Address) 534 ST. Marys St.

15-FILED JUN 5-1923. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 3/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Acute Nephritis
(Autopsy showed, marked jaundice, blood cells in kidneys, lymphatic involved) (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

6/4/23 1923. (Address) 5pi E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem DATE OF BURIAL. 5/6 1923

20-UNDERTAKER. Samuel T Wemsley ADDRESS 518 Mott

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76420

CERTIFICATE OF DEATH.

31 ✓ D76420

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. M. T. H. ST. 14 WARD)

2-FULL NAME Dorothy Newby

(a) RESIDENCE NO. 1834 McCulloh ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Black | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20- 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James H Newby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mamie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) James H Newby 1834 McCulloh St

15 JUN 5 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/12/23, 19 , to 6/3/23, 19 .

that I last saw h[illegible] alive on June 3 [illegible], 1923,

and that death occurred, on the date stated above, at 5.40 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 9 mos. 3 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) F. L. Bagliatea, M. D.

, 19 (Address) M. J. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem | DATE OF BURIAL: 6/6 1923

20 UNDERTAKER: Samuel T Hinsley | ADDRESS: 578 W Balto St

—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS

Spec.—8-24-14—M. & S.—2000 Blks.

SIMPSON

D76421

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D76421

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1621 Milliman ST.; 7 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matthias Simpson

(Residence in Baltimore: No. 1621 Milliman St.; 49 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M.

4-COLOR OR RACE, C.

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (write the word.) Married

6-DATE OF BIRTH, April 6 (Month) (Day), 1873 (Year)

7-AGE, 50 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Wm Simpson

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Margaret Wing

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Cole.

(Address) 1621 Milliman St.

15-

Filed JUN 5-1923 191... ROBERT R. KRAUTER, Clerk.
Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 2, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15, 1923, to June 2 1923, that I saw h... alive on June 1st 1923, and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... yrs. ... mos. 1/2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 1 yrs. ... mos. ... ds.

(Signed) ... M. D.

June 4, 1923 (Address) 3454 W. Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL Leakins Cemetery — DATE OF BURIAL, June 5 1923

20-UNDERTAKER Mrs. R. V. Elliott — ADDRESS 1224 Eutaw Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D76422

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D76422

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1831 Lorman ST. 15 WARD)

2-FULL NAME Samuel Davis

(a) RESIDENCE NO. 1831 Lorman ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	+	+	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Co.

PARENTS

10 NAME OF FATHER: Henry Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co. Md

12 MAIDEN NAME OF MOTHER: Maria Sanders

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co. Md

14 Informant: Gina Gordley (Address) 1831 Lorman Street

15 FILED JUN 5-1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 4 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1923 to June 4, 1923. that I last saw him alive on June 4, 1923, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Prolapation of heart.

(duration) — yrs. — mos. 18 ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis Incidental

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Charles E. Clark, M. D.

June 5, 1923 (Address) 1306 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ST. THOMAS Cemetery — DATE OF BURIAL: June 6 1923

20 UNDERTAKER: Mrs. R. A. Elliott — ADDRESS: Ashland

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76423

CERTIFICATE OF DEATH.

100-801 ✓ D76423

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2201 - Hunter ST. 17 WARD)

2-FULL NAME Glendora Faulkner

(a) RESIDENCE. NO. 2201 - Hunter ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Faulkner

6 DATE OF BIRTH (month, day, and year) May 8 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Montgomery Co., Md

PARENTS

10 NAME OF FATHER John Spriggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Montgomery Co., Md

12 MAIDEN NAME OF MOTHER Catherine —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Charles Faulkner
(Address) 2201 - Hunter St

15 JUN 5 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1923

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1923, to June 2, 1923, that I last saw h[illegible] alive on June 2, 1923, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Spinal tap test.

(Signed) Louis E. Flamm M. D.

, 19 (Address) 211-E-20 = St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	June 5 1923
20 UNDERTAKER Brown & Richardson	ADDRESS 1140 W. Balto St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21- E.B.R.S.—400 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76424 CERTIFICATE OF DEATH. 75-001 D76424

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St.,..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street nod number.)

2-FULL NAME John T. Lennon

(a) Residence No. Bay View Asylum St.,..... Ward.....
(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	W

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1847

7-AGE.	If LESS than 1 day.
75 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

14- (Informant) Municipal Hospital Record

(Address)

Filed JUN 5 - 1923 19.. ROBERT R. KRAUTER, Burial Permit Clerk.

0445

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 1, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 22 19 23 to June 1 19 23

that I last saw h. im alive on June 1 19 23

and that death occurred, on the date stated above, at. 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis and Hypertension

Left Hemiplegia (Residual)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Terminal) (Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McPowell, M. D

6-4-, 19 23 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
	5....., 19....

20-UNDERTAKER.	ADDRESS
Commissioner Health.	JUN 5 - 1923

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec-12-23-21—E.B.R.S.—400 Bks.

Roskelly.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D76425 D76425

CERTIFICATE OF DEATH.

152

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Roskelly

(a) Residence No. 617 E. 35th St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Bessie Roskelly

6-DATE OF BIRTH (month, day and year): May 8 185[illegible] ✓

7-AGE. 71 yrs. 7 mos. 26 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (City or town) (State or Country): England

PARENTS.

10-NAME OF FATHER: Robert Roskelly

11-BIRTHPLACE OF FATHER (city or town) (State or Country): England

12-MAIDEN NAME OF MOTHER: Mamie Richards

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore, Md.

14- (Informant): Municipal Hospital Records

(Address):

15- Filed JUN 5-1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 4, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1923 to June 4, 1923 that I last saw h. alive on June 3, 1923 and that death occurred, on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows:

Senility

Carcinoma of Face (Left

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McPowell M. D.

6-4-, 1923 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION OR~~ REMOVAL: Druid Ridge DATE OF BURIAL, JUN 6 1923

20-UNDERTAKER: Geo W. Little ADDRESS 2708 EDMONDSON AVE.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76426

CERTIFICATE OF DEATH.

45 D76426

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4253 Park Heights ST.: 15 WARD)

2-FULL NAME Frank Tinsley

(a) RESIDENCE. No. 4253 Park Heights ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word): Widowed

5a If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of: Eugenia Tinsley

6 DATE OF BIRTH (month, day, and year): Oct 25 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: B & O R R

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles Tinsley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mary J. Hewitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Geo W Little 2700 Edmondson Ave

15 Filed ..., 19... JUN 5 1923 ROBERT R. KRAMER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 4. 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 15 1923 to June 4 1923 that I last saw him alive on June 4. 1923 and that death occurred, on the date stated above, at 3:20 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Omentum with development of metastasis in heart.

(duration) ... yrs. ... mos. 2 da.

CONTRIBUTORY (Secondary) Sarcoma Omentum.

(duration) ... yrs. 6 mos. ... da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5-4-1923

Was there an autopsy? No

What test confirmed diagnosis? Operation. Micro.

(Signed) James S Ashcraft, M. D.

June 5, 1923 Address 4012 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: JUN 7 1923

20 UNDERTAKER: Geo W Little

ADDRESS 2700 EDMONDSON AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76427

CERTIFICATE OF DEATH.

32 D76427

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 N. Rose ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Mc Sorley

(a) RESIDENCE. No. 120 N Rose st ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 30 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: John Mc Sorley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Rose Ritner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): John Mc Sorley 120 N Rose st

15 Filed JUN 5 - 1923 19

ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 4 1923

17 I HEREBY CERTIFY, That I attended deceased from May 27 1923 to June 4 1923 that I last saw him alive on June 4 1923 and that death occurred, on the date stated above, at 10.15 A m.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis 6

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac Palpitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jno. W. J. Power M. D.

19 (Address) 504 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: June 6 1923

20 UNDERTAKER: Jno F Enochson — ADDRESS: 1106 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76428

CERTIFICATE OF DEATH.

91-002 ✓

D76428

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 N Duncan ST.: 7 WARD)

2-FULL NAME Rosa Svehla

(a) RESIDENCE. NO. 715 N Duncan st ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Chas Svehla

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary Bidlingmayer
(Address) 715 N Duncan

15 Filed JUN 5-1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1923

17 I HEREBY CERTIFY, That I attended deceased from May 24 1923 to June 4 1923 that I last saw her alive on June 4 1923 and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis A. W. Krause, M. D.

. 19 (Address) 2500 E. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 7 1923

20 UNDERTAKER James Enoch Son ADDRESS 1906 Orleans

Spec.—1-10-21—M&T—1500 Bks.

D76429

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76429

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4009 Reisterstown Rd ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm H Daw

(a) RESIDENCE No. 4009 Reisterstown Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of / WIFE of Ida Daw

6 DATE OF BIRTH (month, day, and year) Dec 23, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	6.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer & Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Wm Daw

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Butterhall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Ida Daw

(Address) 4009 Reisterstown Rd

15 Robert F. Harrison, .19 Registrar

Burial Permit Clerk.

JN 5-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4- 1923

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to June 4, 1923, that I last saw h alive on June 4, 1923, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Ch. Interstitial Nephritis

(duration) several yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Uraemia

(Signed) Geo W Dorff M. D.

6/4, 1923 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL June 6 1923

20 UNDERTAKER Robt F Inness

ADDRESS W. Bway

*B.—WRITE LEGIBLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76430

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76430

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 76 WARD)

2-FULL NAME Sarah Warrington

(a) RESIDENCE NO. Bay View Hospital. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	77			

77

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records. (Address)

15 Filed ..... 19 Registrar

Burial Permit Clerk.

N 5-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from September 19, 20 to June 4, 1923,

that I last saw her alive on June 4, 1923

and that death occurred, on the date stated above, at 7:45 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast,

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) A. M. Shipley, M. D.

6-5-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cem. DATE OF BURIAL June 6 1923

20 UNDERTAKER Wm. C. Black ADDRESS 927 Broadway

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76431

HEALTH DEPARTMENT—CITY OF BALTIMORE

31

D76431

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2975 Bernard St., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William L. Eggleston

(a) RESIDENCE NO. 2975 Bernard St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Edith May Eggleston

6 DATE OF BIRTH (month, day, and year) Feb 17 1882

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
41	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Charles T. Crabson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Edith M Crabson

(Address)

15 JUN 5-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to June 5, 1923, that I last saw him alive on June 5, 1923, and that death occurred, on the date stated above, at 4.20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (duration) yrs. 9 mos — ds.

CONTRIBUTORY (Secondary) Tubercular Enteritis (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes. Date of May 10-23.

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) H J Hanna, M. D.

6-6, 1923 (Address) 1822 W Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's H. DATE OF BURIAL: June 6 1923

20 UNDERTAKER: H. S. Marshall ADDRESS: 339 Fallsway

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D76432

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76432

CERTIFICATE OF DEATH.

182

1-PLACE OF DEATH Spring Gardens,

CITY OF BALTIMORE: (No. off Broening Park. ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry E. Ledley.

(a) RESIDENCE NO. 1215 Briscoe St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. 8 mos. 28 ds. How long in U. S., If of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) September, 6th. 1905.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	8	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Printer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Reliable Printing Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John P. Ledley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Dora M. Mertz.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Dora M. Ledley. (mother)
(Address) 1215 Briscoe St.

15 JUN 5-1923, 192 Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.
Fell from a boat.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner)

June, 4th, 1923 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	June 6th 1923
20 UNDERTAKER	ADDRESS
D. Schlosman Mem. Home	1039 E. Monument St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D76433

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76433

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3019 Baker St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary A. Gorrell.

(a) Residence No. 3019 Baker St. — St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of — 1853

6-DATE OF BIRTH (month, day and year) 1853

7-AGE, 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Hartford Co. Md

PARENTS.

10-NAME OF FATHER, Theo. Gorrell —

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md —

12-MAIDEN NAME OF MOTHER, Margaret Bullock.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Delaware

14-

(Informant) George P. Gorrell

(Address) 3306 Waterworks ave

15-

Filed 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 5-1923

17- I HEREBY CERTIFY, That I attended deceased from May 12th, 1923 to June 5th, 1923

that I last saw her alive on June 5th, 1923

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Colon.

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Isaac C. Dickson M. D.

. 19 (Address) 3055 W North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Harford Co Md — DATE OF BURIAL, June 6, 1923

20-UNDERTAKER Jos T. Foster — ADDRESS Bel Air Md

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 5 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76434 — CERTIFICATE OF DEATH. — 129 — D76434

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1908 N Franklin ST., 20 WARD)

2-FULL NAME Gertrude R Lobzow

(a) RESIDENCE NO. 1908 N Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John R Lobzow

6 DATE OF BIRTH (month, day, and year) Oct 18 78

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Henry F Jorden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Marie L Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) John R Lobzow 1908 N Franklin

15 Filed JUN 6 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 10 , 1923 , to June 3 , 1923 , that I last saw h alive on June 2 , 1923 , and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Pancreatitis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? X Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopical

(Signed) A. C. Lynch, M. D.

(Address) 4509 Liberty Hgts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	June 6 1923
20 UNDERTAKER W. M. Routson	ADDRESS 2205 N Monroe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76435

CERTIFICATE OF DEATH.

1294 D76435

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1302 Lemmon St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William R. Topping

(a) RESIDENCE. NO. 1302 Lemmon St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) 1302 Lemmon st

(c) Name of employer Worked for himself

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Wm. R. Topping

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Alice Topping (Address) 1302 Lemmon st

15 Filed JUN 6 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb. 1922 . 19 . to June 2 . 1923.

that I last saw him alive on June 2 . 1923.

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Cardio-renal disease

Valvular Heart disease

Interstitial Nephritis

about (duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical picture

(Signed) W. H. Fuperth M. D.

. 19 (Address) 1324 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	June 6th 19

20 UNDERTAKER A. Jones ADDRESS 111 S. Gilmor 24

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76436

CERTIFICATE OF DEATH.

129 D76436

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2232 N. Fayette St. 20 WARD)

2-FULL NAME John Beauregard Hart

(a) RESIDENCE. NO. 2232 N. Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 10 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If ~~married, widowed, or divorced~~ HUSBAND of ~~(or), WIFE of~~ Ida Mulla

6 DATE OF BIRTH (month, day, and year) Aug. 1st, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work City Fire Captain

(b) General nature of industry, business, or establishment in which employed (or employer) City Fire Dept

(c) Name of employer Balto. City Fire Dept

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER James E Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Mulsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Ida Hart
(Address) 2232 N. Fayette St

15 Filed JUN 6 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd, 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 30th, 1922, to June 3rd, 1923, that I last saw him alive on June 3rd, 1923, and that death occurred, on the date stated above, at 6.05 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary) Chr. Nephritis and Toxic Hypertension (duration) Unknown yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) D. Edgar Tarr, M. D.

6/3, 1923 (Address) 2919 Belmont ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 6, 1923

20 UNDERTAKER ADDRESS

Wm Leech for E Davies Son

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76437

CERTIFICATE OF DEATH.

90 D76437

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 Briscoe ST., 21 WARD)

2-FULL NAME Garrett P. Stubblefield

(a) RESIDENCE No. 1003 Briscoe ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed (Ely)

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sarah Matilda Stubblefield

6 DATE OF BIRTH (month, day, and year) July 24, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Glass Works

(c) Name of employer Swindell Bros.

9 BIRTHPLACE (city or town) Gloucester Co. (State or country) Va.

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Julia Shakelford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Florence Boacher
(Address) 1008 Druid Hill Ave.

15 FILED JUN 6 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1923, to June 5, 1923, that I last saw him alive on June 5, 1923, and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

not known (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) John A Buchanan, M. D.

. 19 (Address) 650 Wash Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL June 8 1923

20 UNDERTAKER Wm Cook Sons & Hinkley — ADDRESS

Spec–12-23-21–E.B.R.S.–400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D76438

CERTIFICATE OF DEATH.

74-001 D76438

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Quandt

(a) Residence No. Preston & Valley Sts. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~ Married, ~~Widowed or Divorced~~ (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Walters.

6-DATE OF BIRTH (month, day and year) July 24 1863

7-AGE. 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Grocer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS

10-NAME OF FATHER, Henry Quandt

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Martha Ludwig

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

11- (Informant) Sister Florence

(Address) Preston & Caroline

15- Filed JUN 6 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-4-23

17- I HEREBY CERTIFY, That I attended deceased from ~~19~~ to ~~19~~ 19

that I last saw ~~him~~ her alive on June 4 1923.

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

10 Days (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Warner, M. D.

6/23. 19 (Address) 1133 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION, OR REMOVAL. Loraine June DATE OF BURIAL, 1923

20-UNDERTAKER. Wm Cook ADDRESS 502 E. N. Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76439

CERTIFICATE OF DEATH.

40 ✓ D76439

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Musco Robb

(a) RESIDENCE NO. 704 Warner ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 25 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary Robb

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Jacob Robb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER [illegible]ly ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mary Robb
(Address) 704 Warner St

15 FILED JUN 6 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1923

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1923, to June 4, 1923, that I last saw him alive on June 4, 1923, and that death occurred, on the date stated above, at 7.50 A.m.

The CAUSE OF DEATH* was as follows:

Urinary infiltration with gangrene

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) Ruptured urethra

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of May 29, 1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical & operative

(Signed) Milton C Lang, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	June 6 1923

20 UNDERTAKER C. H. Brown Sons ADDRESS Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76440 D76440

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 N. Arlington ave ST. 18 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Campbell

(Residence in Baltimore: No. 311 N. Arlington ave St.; 58 yrs., — mos., — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Sept 3rd (Month) (Day), 1864 (Year)

7-AGE,	If LESS than 1 day,
58 yrs. 8 mos. 18 ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House-wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Florida

PARENTS.

10-NAME OF FATHER, Abe Barber

11-BIRTHPLACE OF FATHER (State or Country), North Carolina

12-MAIDEN NAME OF MOTHER Fannie C. Womble

13-BIRTHPLACE OF MOTHER (State or Country), Florida

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno. D. Barber

(Address) 311 N Arlington ave

15-JUN 6-1923 ROBERT R. KRAUTER,

Filed....., 191... Burial Permit (Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 4th (Day), 1923 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Feby 1923, to June 5th 1923, that I saw her alive on June 3rd 1923, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus & Adjacent Organs

(Duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Chronic asthenia

(Duration) 5 yrs. 4 mos. ds.

(Signed) A. B. Gladcock M. D.

June 6, 191... (Address) 1812 Madison ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mount Olivet Cemetery	June 6 1923
20-UNDERTAKER John F. Denny	ADDRESS 715 Light St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76441

CERTIFICATE OF DEATH.

90 D76441

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3009 O'Donnell ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary E. Purcell.

(a) RESIDENCE NO. 3009 O'Donnell St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James C. Purcell

6 DATE OF BIRTH (month, day, and year) Dec. 16-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER Henry Rollins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Md

12 MAIDEN NAME OF MOTHER Sara A. League

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant James C. Purcell (Address) 3009 O'Donnell St.

15 Filed JUN 6 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan. , 1922 to June 3 , 1923

that I last saw h alive on Wed. May 30 1923,

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial Asthma.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? — .

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Nathan J. Sander, M. D.

, 19 (Address) 3009 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	June 6 1923

20 UNDERTAKER N. J. Sander & Sons ADDRESS 1210 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76442

CERTIFICATE OF DEATH.

75-001 D76442

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick H. Giblin

(a) RESIDENCE NO. 1628 Asquith St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

0/5

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed JUN 6 1923 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4, 1923

17

I HEREBY CERTIFY, That I attended deceased from September 16 21, to June 4, 1923.

that I last saw him alive on June 4 1923,

and that death occurred, on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis + Hypertension

Right Hemiplegia (Residual)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. McPowell, M. D.

6-4, 1923 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 6/7 1923

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

See Affadavit over

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D76443

D76443

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 Montpelier Ave ST., 9 WARD)

2-FULL NAME Elizabeth Agnes Kroft.

(a) RESIDENCE NO. 932 Montpelier Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Kroft

6 DATE OF BIRTH (Month, day, and year) December 8 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... At Home.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) New York City New York.

PARENTS

10 NAME OF FATHER John Kane

11 BIRTHPLACE OF FATHER (city or town). (State or country) Scotland

12 MAIDEN NAME OF MOTHER Ellen Kirkpatrick

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Scotland

14 Informant Mary Kearney (Niece) (Address) 932 Montpelier Ave

15 Filed JUN 6 - 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 2nd, 1923, to June 4th, 1923, that I last saw him alive on June 4th, 1923, and that death occurred, on the date stated above, at 10.55 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo W Kingsbury M D, M. D.

6/7/1923 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: 6/7 1923

20 UNDERTAKER: George J Ruth — ADDRESS: 1325 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

This is to certify that the name of
the Informant is incorect the same should
read. Mary Kearns. (nuice) personally appeared
before me. Mr George J Ruth and made affadavit
to the said correction on June 12-1923

Seal George J. Ru

Seal George H
Notary Publ

ant neoplasms); *Measles; acute valvular heart disease; Arthritis*, etc. The contributory rent) affection need not be

Example: *Measles* (disease *Bronchopneumonia* (second- t mere symptoms or terminal sthenia," "Anemia" (merely ," "Collapse," "Coma," "Con- Congenital," "Senile," etc.), , "Heart failure," "Hemor- rasmus," "Old age," "Shock," etc., when a definite disease e cause. Always qualify all Childbirth or miscarriage, as " "PUERPERAL *peritonitis*." hich surgical operation was NT DEATHS state MEANS OF S ACCIDENTAL, SUICIDAL, or bly such, If impossible to amples: *Accidental drown- w train—accident; Revolver ic; Poisoned by carbolic acid* e nature of the injury, as consequences (e. g., *sepsis*. nder the head of "Contribu- s on statement of cause of mittee on Nomenclature of ssociation.)

OR FURTHER STATEMENTS
HYSICIAN.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76444 D76444

CERTIFICATE OF DEATH.

146

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 15 WARD)

2-FULL NAME Lillian Lopez.

(a) RESIDENCE NO. 1644 W. N. Avenue ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. North mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Lopez

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Hyman Shapiro

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Rebecca Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Jack Lopez

(Address) 1439 Eutaw St

15 JUN 6-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 21 st. 1923 to June 5th. 1923, that I last saw h alive on June 6th. 1923 and that death occurred, on the date stated above, at 4:30 p m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

about 1 week (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Puerperal sepsis

(duration) yrs. 3½ mos. [redacted] ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis Lackey, M. D.

June 5, 1923 (Address) 1 Marlboro Court

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	June 6, 1923

20 UNDERTAKER	ADDRESS
Jack Lauris	1439 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D76445

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76445 CERTIFICATE OF DEATH. 40 9[illegible]

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 Baker ST.: 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Bankard

(a) RESIDENCE. NO. 1513 Baker ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	79	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER James Bankard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Mary Osbourn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Regina Parsons
(Address) 3016 Calvert ST

15 Filed JUN 6 - 1923 ROBERT R. KRANTZ, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1923

17 I HEREBY CERTIFY, That I attended deceased from June 4 1923 to June 4, 1923
that I last saw her alive on June 4 1923
and that death occurred, on the date stated above, at 7 A. m.
The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY
(Secondary)
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam

(Signed) John D. Quinn, M. D.

6/5 33 (Address) 1507 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount	June 9 1923

20 UNDERTAKER Martin Fahey & Son ADDRESS 824 W Pratt

Cor.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76446

CERTIFICATE OF DEATH.

129

D76446

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 217 S. Exeter ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Hollenweber

(a) RESIDENCE NO. 217 S. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mathilde Hollenweber

6 DATE OF BIRTH (month, day, and year): May 25 R. 1831

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ....min.
	91	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Teamster

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss M. Hollenbyeber. (Address) 217 S Exeter St.

15 Filed JUN 6 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/4 1923

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1923, to June 4, 1923, that I last saw him alive on June 4, 1923, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Myocarditis, Chronic interstitial Nephritis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary): Pulmonary edema

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Jas A O'Donnell, M. D.

6/5, 1923 (Address) 1078 Mott St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	6/6 1923

20 UNDERTAKER	ADDRESS
John A. Moran	3000 E. Baltimore St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Born in Germany
Resided

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76447

74-001 D76447

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat St. 28th Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie M. Wise -

(a) RESIDENCE. No. Mt Hope Retreat St. 28th Ward. Washington D.C.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Mr Wise -

6 DATE OF BIRTH (month, day, and year) Abt - 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	70	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) (?) Ireland -

PARENTS

10 NAME OF FATHER James E. Wise -

11 BIRTHPLACE OF FATHER (city or town) Washington D.C (State or country)

12 MAIDEN NAME OF MOTHER Anne M Roche

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Ireland -

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md -

15 Filed JUN 6 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1923, to June 5, 1923, that I last saw her alive on June 5, 1923, and that death occurred, on the date stated above, at 11. P. m.

The CAUSE OF DEATH* was as follows:

Paralysis - (Cerebral Hem - Post-) 2 yrs & 2 mos ago.

(duration) 2 yrs. 2 mos. 0 ds.

CONTRIBUTORY (Secondary) Senile Psychosis -

(duration) 2 yrs. 2 mos. 0 ds.

18 Where was disease contracted if not at place of death? Washington D.C -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank Flannery, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. DATE OF BURIAL June 6 1923.

20 UNDERTAKER STEWART & MOWEN COMPANY (Mildred T. Wooden, [redacted])

ADDRESS 108 W. NORTH AVE

IF A PERMANENT RECORD. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76448

CERTIFICATE OF DEATH.

45

D76448

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 Fulton Ave (North) ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Margaret E Cole

(Residence in Baltimore: No. Home for the Aged of the M. E. Church St.; ..... yrs., ... mos. ..... ds.)

Life time

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, February 5, 1851
(Month) (Day) (Year.)

7-AGE, 72 yrs. 2 mos. 28 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Howard County Maryland

PARENTS.

10-NAME OF FATHER, Henry Davey

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Sarah Fowler

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Etta Cuddy

(Address) 400 N. Fulton Ave

15- JUN 6 - 1923 ROBERT R. KRAUTER,
Filed....., 191.... Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 4, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from November 4 1919, to June 4 1923, that I saw her alive on June 3 1923, and that death occurred, on the date stated above, at 10 30 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Sigmoid)

(Duration) 4 yrs. One mos. ..... ds.

CONTRIBUTORY (Secondary) Toxaemia

(Duration) 5 yrs. 5 mos. 5 ds.

(Signed) George E. Shannon M. D.

June 5, 1923 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	June 7, 1923
20-UNDERTAKER George J Smith	ADDRESS 1532 Eutaw St

Spec.—8-24-14—M. & T.—2000 Bks.

D76449

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-09 D76449

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Smith Ave (Westport) ST.; 25 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William J. Klein Jr. (6 mo)

(Residence in Baltimore: No. Smith Ave Dorchester Heights St.; ..... yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Infant

6-DATE OF BIRTH, May (Month) 28 (Day), 1923 (Year)

7-AGE, 10 yrs. 10 mos. 8 ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, William J Klein Sr.

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mildred Kittle

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William J. Klein Sr

(Address) Dorchester Heights

15-

Filed JUN 6-1923 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 5 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 28 1923, to June 5 1923, that I saw him alive on June 5 1923, and that death occurred, on the date stated above, at 8 p m.

The CAUSE OF DEATH* was as follows:

Premature Birth

6 mos

(Duration) 10 yrs. 10 mos. 8 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Raymond S Adams M. D.

June 6, 1923 (Address) Catonsville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Carmel Cemetery

DATE OF BURIAL, June 6 1923

20-UNDERTAKER Zirkler & Zirkler

ADDRESS 1739 E Eager St

Spec.—1-10-21—M&T—1500 Bks.

D76450

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

8 D76450

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 Church (Curtis Bay) ST., 23 WARD)

2-FULL NAME Anna Papiers

(a) RESIDENCE NO. 121 Church ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 19-1920

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Papiers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Helen Zylozak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Steve Papiers (Address) Curtis Bay

15 Filed JUN 6-1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1923

17 I HEREBY CERTIFY, That I attended deceased from May 31. 1923. to June 5. 1923.

that I last saw h alive on June 3. 1923

and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia following measles (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. L. Hopkins, M. D.

June 5. 1923 (Address) Curtis Bay Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A.N.C. DATE OF BURIAL 6/6 1923

20 UNDERTAKER Wm Fidelkowski ADDRESS 1618 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76451

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓ D76451

1-PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 23 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Gough

(a) RESIDENCE NO. 1623 Hanover ST., WARD C

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 13-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
		8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Douglas Gough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lena Webb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. M. Mullen

(Address)

15 Filed JUN 6-1923 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1923

17

I HEREBY CERTIFY, That I attended deceased from May 22, 1923, to June 5, 1923.

that I last saw her alive on June 5, 1923.

and that death occurred, on the date stated above, at 4.45 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

~~2 days~~ (duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) — (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Leon Freedom M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fowden Park Cem. DATE OF BURIAL: June 7 1923

20 UNDERTAKER: F.A. Krause & Son ADDRESS: 7037 Hanover St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(6)

S.A. KESSLER

D76452

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76452

CERTIFICATE OF DEATH.

REGISTERED No. C 100-867

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1411 N. Bentalou St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Wisner

(Residence in Baltimore: No. 1411 N. Bentalou St. St.; yrs., 9 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	white	single

6-DATE OF BIRTH, Aug. 9, 1922
(Month) (Day) (Year)

7-AGE, ...yrs. 9 mos. 27 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Raymond Wisner

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Anna E. Kuntz

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna E. Wisner

(Address) 1411 N. Bentalou St.

15-

JUN 6—1923 191 ROBERT R. KRAUTER,
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 5, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an.....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry)
.....find that said deceased came to.....death on the day stated above.
The CAUSE OF DEATH* was as follows:

.....Broncho-pneumonia

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

..... (Duration).....yrs.....mos.....ds.

(Signed) .....M. D.
(Coroner.)

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
London Park Cem	June 6, 1923
20-UNDERTAKER	ADDRESS
Jos Sparrows Son	217 S. Reg

N. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

KODAK

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76453

CERTIFICATE OF DEATH.

111-001

D76453

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1618 Eutaw Place ST., WARD)

2-FULL NAME Robert Dickson

(a) RESIDENCE NO. 1618 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jessie Dickson

6 DATE OF BIRTH (month, day, and year) June 27 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Insurance

(b) General nature of industry, business, or establishment in which employed (or employer) Manager.

(c) Name of employer

9 BIRTHPLACE (city or town) Campbelltown (State or country) Scotland

PARENTS

10 NAME OF FATHER Wm. Dickson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Robert Tweeddale (Address) 1618 Eutaw Place

15 FILED JUN 6-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/5/1923.

17 I HEREBY CERTIFY, That I attended deceased from June 2nd, 1923, to June 5th, 1923, that I last saw him alive on Tues June 5th, 1923, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Hemetemesis - due to perforation of Gastric Ulcer into an Artery

Duration of the Ulcer unknown probably (duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Advanced Age & 79 years old exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of 0

Was there an autopsy? no

What test confirmed diagnosis? Chemic & microscopic by Dr Paul B Clough and

(Signed) John C Hemmeter, M. D.

, 19 (Address) 739 University Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	6/7/1923
20 UNDERTAKER	ADDRESS
David Sondheim	118-20 W. Mt. Royal Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76454

CERTIFICATE OF DEATH.

31

D76454

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2659 Loyola South Way (Ward)

2-FULL NAME Charles S Scheper

(a) RESIDENCE NO. 2659 Loyola, South ST. Way WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Minnie A Scheper

6 DATE OF BIRTH (month, day, and year): July 25-1886

7 AGE: Years 36 Months 10 Days If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): Penna R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ind.

PARENTS

10 NAME OF FATHER: Henry Scheper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant: Mrs Chas J Scheper. (Address) 2659 Loyola South Way

15 Filed JUN 6 1923, 19 ROBERT R. KRAUTER Burial Permit Registrar. Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 4 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to June 4, 1923, that I last saw him alive on June 4, 1923, and that death occurred, on the date stated above, at 1. P m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) Pulmonary & Laryngeal Tuberculosis (duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Jan, 1923.

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Microscopic

(Signed) Chas J Mell, M. D.

, 19 (Address) 2d Belvidere Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Cathedral — DATE OF BURIAL 6/7 1923

UNDERTAKER: John A Moran Sons — ADDRESS E Balto

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76455

CERTIFICATE OF DEATH.

34 D76455

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Robert Botts

(a) Residence No..... Unknown St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Black	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1875

7-AGE. 47 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)..... U H D

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Albert Botts

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. C. Stokes

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Virginia

14- (Informant) Municipal Hospital Records

(Address).....

15- JUN 6-1923 Robert P. Harrison Registrar.

Burial Permit Clerk.

JUN 6 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 2, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 21 19 23 to June 2 19 23

that I last saw h. alive on June 2 19 23

and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Pelvic Disease

(Duration) 1 yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of ?

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) A. M. Shipley M. D.

6-4-, 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL. ....., 19....
20-UNDERTAKER.	ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health.

177

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-19-21—M&T—1500 Bks.

(Percy)

D76456

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76456

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital St., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George R Percy

(a) RESIDENCE NO. 1042 Edmondson Ave ST., WARD

(Usual place of abode) about

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs George R Percy.

6 DATE OF BIRTH (month, day, and year) Feb 7 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
63	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dep Fire Marshall

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Percy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sophia Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Marc Bryant

(Address) Denton Md

Filed JUN 6 1923, 19

Emery T. Harrison

Registrar

(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-5- 1923

17

I HEREBY CERTIFY, That I attended deceased from 6-4- ,1923 , to 6-5- ,1923 ,

that I last saw him alive on 6-5- ,1923 ,

and that death occurred, on the date stated above, at 4 15 p m.

The CAUSE OF DEATH* was as follows:

General carcinomatosis

primary genital probably in

stomach

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J E King, M. D.

, 19 (Address) Union H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Denton, Md. DATE OF BURIAL: June 7 1923

20 UNDERTAKER: John O. Mitchell ADDRESS: 1701 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76457

CERTIFICATE OF DEATH.

129 D76457

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (a) NO. 2814 Boarman Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances J. Griswold

(a) RESIDENCE NO. 2814 Boarman Ave WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank L. Griswold

6 DATE OF BIRTH (month, day, and year) Aug 3-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Wm Pease

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER — Beidelman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs L. C. Ensey

(Address) 2814 Boarman Ave

15 Filed June 6 1923 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1922 to June 5 1923.

that I last saw her alive on June 5 1923.

and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Myocarditis

(duration) Over 1 year.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Harry C. Offer M. D.

June 6 1923 (Address) 1203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holberg, N. Y.	June 6, 1923

20 UNDERTAKER ADDRESS

John O. Mitchell, 1201 W Fayette.

Spec.—1-10-21—M&T—1500 Bks.

D76458

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76458

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 Mott St ST., 5 WARD)

2-FULL NAME Maud Ellis

(a) RESIDENCE NO. 417 Mott St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	C.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edward Ellis.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
33	-	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work.

(b) General nature of industry, business, or establishment in which employed (or employer) House Work.

(c) Name of employer Jane

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John Robinson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown.

14 Informant Edward Ellis
(Address) 417 Mott Street.

15 Filed 1923 Robert P. Harrison
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1923

17

I HEREBY CERTIFY, That I attended deceased from March 16, 1923, to June 5, 1923

that I last saw her alive on June 5, 1923

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Carcinoma of Stomach 2 ds.
(duration) yrs. mos.

CONTRIBUTORY (Secondary) Carcinoma of Stomach (duration) yrs. 4 mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward M.D.

6-6, 1923 Address 18 Orsor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL June 8 1923

20 UNDERTAKER Mrs. R. C. Ellis ADDRESS 227 Ashland Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76459

CERTIFICATE OF DEATH.

161-D76459

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1247 Orleans ST., 5 WARD)

2-FULL NAME Infant Jackson

(a) RESIDENCE NO. 1247 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 6/3/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	—	11 hrs.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ala.

12 MAIDEN NAME OF MOTHER Pearl Sallett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fla

14 Informant Joseph Jackson

(Address) 1247 Orleans St

15 6-1923 Robert P. Harrison; Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/3/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 6/3/23 to 6/3/23. 1923.

that I last saw h in alive on 6/3/23. 1923

and that death occurred, on the date stated above, at 4:00 P m.

The CAUSE OF DEATH* was as follows:

Premature Labor

(duration) Unk yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Undetermined

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of. —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Gus Bowley, M. D.

6/4, 1923 (Address) 908 E Shoop St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Cemetery

DATE OF BURIAL June 6 1923

20 UNDERTAKER Mrs. Rola Elliott

ADDRESS Mt Winans

Postal Permit Clerk

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76460 D76460

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2107 Hilton St., ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ellen Pfister

(a) RESIDENCE No. 2107 Hilton St., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph H. Pfister

6 DATE OF BIRTH (month, day, and year) Dec. 28, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas Gaughran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Joseph H. Pfister (Address) 2107 Hilton St.

15 Filed [illegible], 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar - 14, 1923, to June 5 -, 1923, that I last saw h[illegible] alive on May 5 -, 1923, and that death occurred, on the date stated above, at 12:30 A m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration with original pains. Arterio-sclerosis.

(duration) - yrs. 6 mos - ds.

CONTRIBUTORY (Secondary) Acute dilatation, cardiac

(duration) - yrs. - mos. 1 hr ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? - Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wesley Cole, M. D.

6 . 1923 (Address) 2202 Environs.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 7/23
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 Calvert St.

(over)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

163876, D76461

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D76461

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. " " " ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George C. Smith

(a) RESIDENCE NO. 704 N. Bond St. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Unknown

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced (or) WIFE of HUSBAND of: Lou Smith (mother)

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 18 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Fisherman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia.

PARENTS

10 NAME OF FATHER: George Smith.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Lou Campbell.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): JOHNS HOPKINS HOSPITAL.

15 Robert F. Harrison, Registrar. 19 . Burial Permit Clerk.

JUN 6-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 5 1923

17 I HEREBY CERTIFY, That I attended deceased from May 23 . 1923 . to June 5 . 1923 . that I last saw him alive on June 5 . 1923 . and that death occurred, on the date stated above, at 11.20 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis —

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary): Pleural effusion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Residence —

Did an operation precede death? No Date of

Was there an autopsy? No —

What test confirmed diagnosis? Tuberculin?

(Signed) E. Cowles Andrus, M. D.

. 19 (Address) Johns Hopkins Hosp —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Catonsville M. A.

DATE OF BURIAL: 6-6 1923

20 UNDERTAKER: Geo. T. G. Gibson

ADDRESS: Catonsville Md.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76462 ✓ 129 D76462

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 114 S. Ann St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Weronika Wisniewski

(a) Residence No. 114 S. Ann St., Ward.....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, X Widowed, or Divorced. (Write the word.)
Female	White	

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Stanislaus Wisniewski

6-DATE OF BIRTH (month, day and year) april 15 1867

7-AGE. 56 yrs. 1 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Poland
(State or Country).

PARENTS.

10-NAME OF FATHER, Paul Koprowski

11-BIRTHPLACE OF FATHER (city or town)..... Poland
(State or Country).

12-MAIDEN NAME OF MOTHER, Justyna Mysliwek

13-BIRTHPLACE OF MOTHER (city or town)..... Poland
(State or Country).

11- (Informant)..... Stanislaus Wisniewski
(Address)..... 114 S Ann St.

15- Robert P. Harrison,
19..... Registrar.
Burial Permit Clerk.

JN 8-1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 3/23

17- I HEREBY CERTIFY, That I attended deceased from June 1921 to June 3rd 1923 that I last saw h[illegible] alive on June 3rd 1923 and that death occurred, on the date stated above, at 9.15 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Mitral Regurgitation
Cardiac Hypertrophy

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) A. Flis, M. D

June 5th, 1923 (Address) 24 E Biddle

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	June 7 1923

20-UNDERTAKER. ADDRESS

John M. Weber 1803 Bank St.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76463 ✓ D76463

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 St Paul St ST. 12 WARD) 74-6

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thad Ways

(Residence in Baltimore: No. 1819 St Paul St St.; Lifetime mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 7, 1869
(Month) (Day) (Year)

7-AGE, 53 yrs. 3 mos. 1 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Insurance
(b) General nature of industry, business, or establishment in which employed (or employer): Business

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Chas E. Ways

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Margaret Beyer

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine McDonnell Ways

(Address) 1819 St. Paul St

15-

JUN 6-1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 5/23, 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from ....191 , to ....191 , that I saw h alive on ....191 , and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed).....M. D.

....., 191... (Address).....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....de. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Cathedral Cemetery

DATE OF BURIAL, 6/7..., 1923

20-UNDERTAKER Chas F. Crane & Son

ADDRESS 1111 N Howard

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76464

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76464

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 328 S Bond ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Steve Kowalazeh

(a) RESIDENCE. No. 328 S Bond ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 11 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work - Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Andrew Kowalszoh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Lona Szymanetha

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Andrew Kowalazeh
(Address) 328 S Bond

15 Filed Robert P. Harrison; Registrar
Burial Permit Clerk.

JUN 6-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 19.. to June 6th, 1923, that I last saw him alive on June 5th, 1923, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute Gastro-Enteritis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

What test confirmed diagnosis? there an autopsy?

(Signed) Jacob L Libinson M. D.

(Address) 303-B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	June 7 1923
20 UNDERTAKER	ADDRESS
Wendell Dysel & Son	373 Hanover

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76465

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76465

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1231 Spring & Morrell Park 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... John Jeffery

(Residence in Baltimore: No. 740 Hamilton St.; yrs. unknown mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

6-DATE OF BIRTH. March (Month) 17 (Day) 1851 (Year)

7-AGE. 73 yrs. 2 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of industry, business, or establishment in which employed (or employer) City Boss Ride

9-BIRTHPLACE, (State or Country). Balto Co

PARENTS.

10-NAME OF FATHER. Unknown Jeffery

11-BIRTHPLACE OF FATHER, (State or Country). Balto Co

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence Jeffery

(Address) 703 Bay St. Hamilton

JUN 7 - 1923

ROBERT R. KRAUTER,
Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 6 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cirrhosis Liver

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia Endocarditis Aortic (Duration) yrs. mos. ds.

(Signed) James W. Preston M. D. (Coroner)

June 6 1923 (Address) 707 E. Chase St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. St Mary's Hampden June 9 1923 DATE OF BURIAL.

20-UNDERTAKER. CHENOWETH & SON, ADDRESS 3617 CHESTNUT AVE.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D76466

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D76466

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. ..... ST., 12 WARD)

2-FULL NAME Henery Golden

(a) RESIDENCE NO. 1330 Whatcoat ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bras Co Md

PARENTS

10 NAME OF FATHER James Golden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lotie Sutton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Fayred Golden

(Address) 911 Virginia Ave

15 JUN 7 1923 ROBERT H. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 5 1923. to June 6 1923.

That I last saw him alive on June 6 1923.

and that death occurred, on the date stated above, at 12:15 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? P S E.

(Signed) Harold C. Pilsbury M. D.

19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	June 8th 1923

20 UNDERTAKER Parsons & Wright ADDRESS 1649 McCulloh

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76467

CERTIFICATE OF DEATH.

D76467

1-PLACE OF DEATH 3248 Paysm.

Registered No.....

City of BALTIMORE: (No. 3248 Paysm St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Stey

(a) Residence No. 324 S. Payson St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 10 1921

7-AGE. 2 yrs. 4 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto Md.

PARENTS.

10-NAME OF FATHER. Jack Stey

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant) Mrs. Wm. Bosley

(Address) 3248 Payson

15- FILED JUN 7 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/5/23

17- I HEREBY CERTIFY, That I attended deceased from 5/28/23, 19..., to 6/5/23, 19...

That I last saw h— alive on 6/5/23, 19...

and that death occurred, on the date stated above, at 8 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Measles

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there no autopsy? no

What test confirmed diagnosis? no

(Signed) G. F. Wheeler, M. D.

6/6/23, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer

DATE OF BURIAL. June 7, 1923

20-UNDERTAKER. Harry H. Wetzke

ADDRESS 1531 N. Fulton Ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76468

CERTIFICATE OF DEATH.

D76468

1-PLACE OF DEATH

REGISTERED NO. 74-081

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 1611 Alice Ann ST., 7 WARD)

2-FULL NAME Wilhelmina Schmidt

(a) RESIDENCE NO. 1611 Alice Ann ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhelm Schmidt

6 DATE OF BIRTH (month, day, and year) Feb. 3, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER August Ruppersberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Anna Schmidt

(Address) 1611 Alice Ann St

JUN 6 - 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1923

17

I HEREBY CERTIFY, That I attended deceased from March. 1923 to June 5 - 1923,

that I last saw h or alive on June 5 1923,

and that death occurred, on the date stated above, at 1.45 9 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage —

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Prostatism (Heart)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Max Brandt M. D.

, 19 (Address) 125 E Biddle —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	June 7 1923
20 UNDERTAKER H. Sander Sons	ADDRESS 1710 Park Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D76469 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76469

CERTIFICATE OF DEATH.

5129

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 5 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Ritmeister

(a) Residence No. 920 E. Baltimore St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): 1873

7-AGE: 50 yrs. — mos. — ds. If LESS than 1 day ....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Unable to obtain

(b) General nature of industry, business, or establishment in which employed (or employer): further history.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

13- (Informant) Municipal Hospital Records

(Address)

JUN 7 1923

ROBERT R. KRAMER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 2, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 31 19 23 to June 2 19 23

that I last saw him alive on June 1 19 23

and that death occurred, on the date stated above, at 9:00 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. M. Powell M. D.

6-4- 19 23 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Hebrew Cem. DATE OF BURIAL: June 7 1923

20-UNDERTAKER: Jack Levin ADDRESS: 1439 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76470

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76470

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 210 N. Castle ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Hennefle

(a) RESIDENCE NO. 210 N. Castle ST., 6 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late anna Hennefle.

6 DATE OF BIRTH (month, day, and year) Feb. 20th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	3	16	

8 OCCUPATION OF DECEASED Pattern Maker

(a) Trade, profession or particular kind of work Mill Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) National Casket Co.

(c) Name of employer Geo. J. Baltz & Sons

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank Hennefle
(Address) 3104 McElderry St.

15 JUN 7 - 1923 ROBERT R. KRAETER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5th 1923

17 I HEREBY CERTIFY, That I attended deceased from 1919. 19 . 19 June 5 . 1923.

that I last saw him alive on June 2 1923

and that death occurred, on the date stated above, at 4.45 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Senile Anemia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Symptoms

(Signed) H G Roby M. D.

. 19 (Address) 1907 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 9th 1923
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Sephus

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76471 ✓ D76471

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 822 Lemon ST.: 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Asterin E. Sephus

(a) RESIDENCE. NO. 822 Lemon St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Maried

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Seafus

6 DATE OF BIRTH (month, day, and year) Aug 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Worke

(b) General nature of industry, business, or establishment in which employed (or employer) X

(c) Name of employer X

9 BIRTHPLACE (city or town) (State or country) Annarundel Co

PARENTS

10 NAME OF FATHER Henry Blackston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Bayly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant William Seafus

(Address) 822 Lemon St

JUN 7 - 1923

ROBERT F. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1923

17 I HEREBY CERTIFY, That I attended deceased from June 2 . 1923 . to June 5 . 1923.

that I last saw her alive on June 4 . 1923.

and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Interanteritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Exam

(Signed) A. B. Fiselle M. D.

June 1923 (Address) 712 Park Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest grove Harman annarundel Co

DATE OF BURIAL: June 7 1923

20 UNDERTAKER: John R Owens

ADDRESS: 578 Dolphin St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76472

CERTIFICATE OF DEATH.

44 D76472

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 945 Linden Av ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Garrison P. Ellison

(Residence in Baltimore: No. 945 Linden Av St.; 12 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Unknown (Month) (Day), 1873 (Year)

7-AGE, 50 yrs. — mos. — da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Cook
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), N C

PARENTS.

10-NAME OF FATHER, Garrison Ellison

11-BIRTHPLACE OF FATHER (State or Country), N C

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Iola Ellison

(Address) 945 Linden Ave

15- JUN 7-1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 5 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 6 1923, to June 5 1923, that I saw him alive on June 5 1923, and that death occurred, on the date stated above, at 9 25 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach ?

(Duration) yrs. 6 mos. da.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 4 da.

(Signed) S B Hughes M. D.

June 6, 1923 (Address) 1423 S. Hill St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, 6/8, 1923

20-UNDERTAKER Geo H Holland ADDRESS 1631 D H Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Bks.

D76473

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

118-001 D76473

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) Franklin Sq. Hospital (ST.) 20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cunigunda Bauer

(a) RESIDENCE No. 2210 Eagle Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): 1864 Sept 29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: George Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Magret —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frank Bauer

(Address): 2210 Eagle St

15 JUN 6 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6 6 1923

17

I HEREBY CERTIFY, That I attended deceased from 6-1-, 1923, to 6-6, 1923,

that I last saw her alive on 6-6, 1923,

and that death occurred, on the date stated above, at 2:45 P. M.

The CAUSE OF DEATH* was as follows:

Ventricular stasis, Cardiac stimulated

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Terminal, Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 6-1-23

Was there an autopsy? Yes

What test confirmed diagnosis? Op.

(Signed) H. C. Burns, M. D.

6/5, 19 23 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	June 8 1923

20 UNDERTAKER: Knell & Son

ADDRESS: 1729 W Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76474

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D76474

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelia C Pfannenstiel

(a) RESIDENCE NO. 1224 W Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herbert C. Pfannenstiel

6 DATE OF BIRTH (month, day, and year) Aug 14, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	33	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Joyce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Laura Berger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Herbert C. Pfannenstiel
(Address) 1224 W. Lexington St

15 JUN 7 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-5-23 19

17

I HEREBY CERTIFY, That I attended deceased from 5-23-23, to 6-5-23,

that I last saw h[illegible] alive on 6-5-23, 19,

and that death occurred, on the date stated above, at 10 40 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 5-24-23

Was there an autopsy? Thoracotomy No

What test confirmed diagnosis? Gross Symptoms

(Signed) S. A. Lamptinis, M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL June 8 1923

20 UNDERTAKER Mr. Mrs. John H. Teufel & Son — ADDRESS 801 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lobar Pneumonia

Spec.—1-10-21—M&T—1500 Rks.

Forney.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1634 D76475 — D76475

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 117

CITY OF BALTIMORE: (No. ..... ST., 76 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Forney

(a) RESIDENCE No. 808 S. 7th St. ... ST., Highlandtown ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 27, 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER ~~Patrick~~ Thos. Forney.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Elsie Frese.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant JOHNS HOPKINS HOSPITAL.

(Address)

15 JUN 7 - 1923 ROBERT B. KRAMER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1923

17

I HEREBY CERTIFY, That I attended deceased from May 23, 1923 to June 6, 1923.

that I last saw h alive on June 6, 1923

and that death occurred, on the date stated above, at 5:40 a m.

The CAUSE OF DEATH* was as follows:

Appendix abscess.

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary): Post-Operative Intestinal Obstruction

+general peritonitis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes. Date of {5-23-23. 6-5-23

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Emil H. Bagley, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. DATE OF BURIAL: June 8th 1923.

20 UNDERTAKER: Mrs. Mrs. J. W. Tenfelde Son ADDRESS: 801 N Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76476

CERTIFICATE OF DEATH.

+ 124

D76476

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Andrew Bourne

(a) RESIDENCE NO. Brooklandville Md ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Drug Packer

(c) Name of employer Thorpe Dohme

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

JUN 7-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1923 to June 6, 1923

that I last saw him alive on June 6, 1923

and that death occurred, on the date stated above, at 2h 20m.

The CAUSE OF DEATH* was as follows:

Chr. Cholecystitis

(duration) yrs. 4 mos 7 ds.

CONTRIBUTORY (Secondary) Post Operative Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of June 4/1923

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) B. McKoddell, M.D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	June 8 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E Nort.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76477

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76477

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 325 E. 24th ST. 12 WARD)

2-FULL NAME Charles N. Hensen

(a) RESIDENCE NO. 2936 Guilford ave ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary G. Hensen

6 DATE OF BIRTH (month, day, and year) June 4 1878

7 AGE Years 45 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Elec. Eng.

(b) General nature of industry, business, or establishment in which employed (or employer) Spann Mf.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10 NAME OF FATHER dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind.

14 Informant Mary G. Hensen

(Address) 2936 Guilford ave

JUN 7 - 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1923

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1923, to June 6, 1923,

that I last saw him alive on June 5, 1923,

and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis (5, 1, 1)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Caleb N Athey, M. D.

June 6 1923 (Address) 100 S. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem.

DATE OF BURIAL 6/8/ 1923

20 UNDERTAKER J. J. Moran

ADDRESS 300 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Septic Endocarditis
probably due to a
Chronic Rheumatism

Spec.—1-10-21—M&T—1500 Blks.

16269 D76478 — HEALTH DEPARTMENT—CITY OF BALTIMORE — D76478

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. " " " ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Rhoden.

(a) RESIDENCE NO. Franklin Ave. Kasper ST. Edmondson WARD

(Usual place of abode)

Length of residence in city or town where death occurred Not known yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Ella Rhoden, (wife.

6 DATE OF BIRTH (month, day, and year) July 17, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	54.	11.	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER George Rhoden.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital. Records.

15 JUN 8-1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1923

17 I HEREBY CERTIFY, that I attended deceased from April 2, 1923, to June 5, 1923, that I last saw him alive on June 5, 1923, and that death occurred, on the date stated above, at 7.45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pharynx

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Chronic Pneumonitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Chas. W. Cummings M. D.

, 19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Orem Cemetery

DATE OF BURIAL 6/7 1923

20 UNDERTAKER J. J. Moran

ADDRESS 300 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76479

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D76479

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2502 Allendale Road St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Sarah E. Wylie

(a) Residence No. 2502 Allendale Road St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James H. Wylie

6-DATE OF BIRTH (month, day and year) July 17 1833

7-AGE. 89 yrs. 10 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Roxbury (State or Country), Mass

PARENTS.

10-NAME OF FATHER, Oliver Dennis

11-BIRTHPLACE OF FATHER (city or town) Maryland (State or Country),

12-MAIDEN NAME OF MOTHER, Elizabeth Hilbert

13-BIRTHPLACE OF MOTHER (city or town) Maryland (State or Country),

14- (Informant) H. C. Kilmon

(Address) 2502 Allendale Road

15- JUN 7 1923 Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 6, 1923

17- I HEREBY CERTIFY, That I attended deceased from ..... 1918 to June 6 1923

that I last saw h.r alive on June 5 1923,

and that death occurred, on the date stated above, at 2:06 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Progressive senile debility

(Duration) yrs. 5 mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Stethoscope & Thermometer

(Signed) Geo. T. Kemp M. D

June 6 1923 (Address) St James Apartments

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Greenmount Cem	June 8 1923
20-UNDERTAKER.	ADDRESS
George J. Smith	Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76480

CERTIFICATE OF DEATH.

133 D76480

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 328 W. Hoffman ST., 11 WARD)

2-FULL NAME Sarah Cannon

(a) RESIDENCE NO. 328 W. Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown 1863

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): retired

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): New Market Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Laura A. Brown

(Address) 328 W. Hoffman St

15 JUN 7 1923 JUN 6 1923 ROBERT R. KRANTZ Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 5 1923

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1923, to June 5, 1923

that I last saw her alive on June 5, 1923

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urine anal.

(Signed) P. Gustav Dill M. D.

6/7, 1923 (Address) 1433 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: All Saints Cem

DATE OF BURIAL: 6/8 1923

20 UNDERTAKER: Samuel Hensley

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WARNING—RESERVED FOR BIRTHS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Catarrhal.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76481

CERTIFICATE OF DEATH.

1135 D76481

REGISTERED No. C.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2008 Ettring St. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nathaniel Tiggle

(Residence in Baltimore: No. 2008 Ettring St. St.: yrs., 5 mos., 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
male	col	S

6-DATE OF BIRTH, ... 7, 1917
(Month) (Day) (Year)

7-AGE, ... yrs. 5 mos. 17 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Allen Tiggle

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER Mary Harris

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) 2008 Ettring St

JUN 7-1923 .....R. .....
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ..., 191...
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

....., 191... (Address) .....

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL, 1923
Mt Auburn Cem	June 8

20-UNDERTAKER Samuel Hensley ADDRESS 578 N Eddle

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—8-24-14—M. & T.—2000 Blks.

D76482

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D76482

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 930 Linden Ave ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hester Jolley

(Residence in Baltimore: No. 930 Linden Ave St. Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Unknown, ... (Month) ..... (Day) 1848 (Year)

7-AGE, 75 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Joseph Wells

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Jolley

(Address) 930 Linden Ave

15- JUN 7 - 1923 ROBERT B. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 5, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1 1923, to June 5 1923, that I saw her alive on June 4 1923, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

a Cardio-vascular Disease

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. S. Willard M. D.

6/6, 1923 (Address) 2005 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Lebanon Cem DATE OF BURIAL, 6-8-23

20-UNDERTAKER Samuel D. Beasley ADDRESS 1911 E Eddy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—MAT—1500 Blks. D76483

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76483

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woodlawn ST., Dist. 24 WARD)

2-FULL NAME August Kruger

(a) RESIDENCE NO. Woodlawn Balto. Co. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhelmina Mc. Lean

6 DATE OF BIRTH (month, day, and year) Aug 8 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	89.	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardner

(b) General nature of industry, business, or establishment in which employed (or employer) =

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Kruger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Buchmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wilhelmina Mc Lean

(Address) Woodlawn Balto Co

15 JUN 7 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1923, to June 6 1923.

That I last saw him alive on June 6 1923,

and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis.
Myocarditis.
Chronic parenchymatous Nephritis (duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis about 6 mo (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) W. S. Willett M. D.

June 6 1923 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bonnie Brae DATE OF BURIAL JUNE 1923

20 UNDERTAKER H B Stafford ADDRESS 2236 Eutaw Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D A K

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76484

CERTIFICATE OF DEATH.

148

D76484

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital. ST., 5 WARD)

2-FULL NAME Mildred Bell

(a) RESIDENCE No. 211 N. Spring ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 (Single) Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer): School Girl

(c) Name of employer: -

9 BIRTHPLACE (city or town) (State or country): Washington, D.C.

PARENTS

10 NAME OF FATHER: Richard [redacted]

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Sarah Hanson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. C.

14 Informant (Address): W.W. Gray Johns Hopkins Hospital.

15 Filed JUN 7 - 1923 ROBERT R. KRAETER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1923, to June 5, 1923, that I last saw her alive on June 5, 1923, and that death occurred, on the date stated above, at 10.45 p. m.

The CAUSE OF DEATH* was as follows:

Intra-partum eclampsia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) W.W. Gray, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: June 9 1923

20 UNDERTAKER: Chas H. A. Elliott — ADDRESS: 1725 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should mark CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

K-O

N. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76485

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76485

CERTIFICATE OF DEATH.

38

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Jones

(a) Residence No. 1103 Park Ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	?

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1878

7-AGE.	If LESS than 1 day.
44 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Senator

(b) General nature of industry, business, or establishment in which employed (or employer). Senator

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). ?

PARENTS

10-NAME OF FATHER. George C. Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country). ? in Md

12-MAIDEN NAME OF MOTHER. Litha ? Jones

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). ? Unknown

14-Informant. Municipal Hospital Records

(Address).....

15-FILED JUN 7 - 1923 [illegible] Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 5, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 2 1923 to June 5 1923

that I last saw him alive on June 4 1923

and that death occurred, on the date stated above, at 9:00 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis

C.n.s Syphilis (Grand Mal)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Terminal) (Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H.McPowell M. D

6-6-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Auburn Cem	June 9 1923

20-UNDERTAKER.	ADDRESS
Wm Robert + Elliott	1725 Ashland Ave

Spec- 12-23-21—E.B.R.S.—400 Bks.

D76486

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76486

CERTIFICATE OF DEATH.

5 38

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustus Jenkins

(a) Residence No. 611 N. Central Ave. St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 56 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Black	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): 1867

7-AGE. ..... 55 ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ..... H C

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md.

PARENTS:

10-NAME OF FATHER: Winifred Jenkins

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore, Md.

12-MAIDEN NAME OF MOTHER: Liza Chester

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore, Md.

14- (Informant): Municipal Hospital Records

(Address): .....

15- JUN 7 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 5, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 26 19 23 to June 5 19 23

that I last saw him alive on June 4 19 23

and that death occurred, on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis

C.N.S Syphilis

Peripheral Neuritis (Syphilitic)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (Terminal)

(Duration) ..... yrs. ..... mos. 5 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) W McPowell, M. D.

6-6-. 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: June 8, 1923

20-UNDERTAKER: Jas Robert + Elliott — ADDRESS: 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76487

CERTIFICATE OF DEATH.

D76487

Registered No. 31

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Jennie Burford

(a) Residence No. 1906 W. Lanvale St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Sept. 2 1863

7-AGE. 60 yrs. 8 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John S. Burford

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Julia A. Gough

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14-(Informant) George A. Farley

(Address) 1800 N. Fayette St.

15-FILED JUN 7 - 1923 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6/5/23

17- I HEREBY CERTIFY, That I attended deceased from April 22, 1923, to June 5, 1923, that I last saw h[illegible] alive on May 5, 1923, and that death occurred, on the date stated above, at ....in The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 4½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia. 3 ds.

(Duration) ?? yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Sypms

(Signed) [illegible] M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cem	June 7 1923
20-UNDERTAKER.	ADDRESS
George A Farley	1800 Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76488

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76488

CERTIFICATE OF DEATH.

58-001

1-PLACE OF DEATH Franklin Sq. Hosp.

REGISTERED NO.

CITY OF BALTIMORE: (No. ~~Unk~~) ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam C. Smith

(a) RESIDENCE NO. Evergreen Ave Near Cavalier ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Smith.

6 DATE OF BIRTH (month, day, and year) Feb. 24-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	59	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Conrad Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Elizabeth Smith. (Address) Evergreen Ave. Near Cavalier Ave

15 JUN 7-1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1923.

17 I HEREBY CERTIFY, That I attended deceased from Apr 10, 1923, to June 4, 1923, that I last saw h alive on June 4, 1923 and that death occurred, on the date stated above, at 6.20 p. m.

The CAUSE OF DEATH* was as follows:

Primary anemia (Pernicious type)

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Blood transfusion Date of 6-4-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) A. Hurd Hurlock, M. D.

6/4, 1923 (Address) Maple Ave. Bel. Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL June 8 1923

20 UNDERTAKER Lilly and Zeiler ADDRESS 1038 Wolfe St

Spec.—1-10-21—M&T—1500 Bks.

D76489

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76489

CERTIFICATE OF DEATH.

113

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3421 Elliott St. ST., 26 WARD)

2-FULL NAME Wilhelmina Fries

(a) RESIDENCE NO. 3421 Elliott St. ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 21 - 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Fries.

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Hessler

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Henry Fries
(Address) 3421 Elliott St.

15 JUN 7 - 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to June 6, 1923.
that I last saw her alive on June 6, 1923
and that death occurred, on the date stated above, at 8.30 a. m.
The CAUSE OF DEATH* was as follows:

Gastroenteritis

(duration) ... yrs. ... mos 20 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No Observation

What test confirmed diagnosis?

(Signed) Horace B Tilson M. D.

6/6, 1923 (Address) 315 S. Highland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL June 8 1923

20 UNDERTAKER Lilly & Zile ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76490 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76490

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Harford & Grove Aves. St., 27 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Willenberg

(Residence in Baltimore: No. Harford & grove Aves. St.; yrs., mos., ds.)

1885

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	married

6-DATE OF BIRTH. August 2/1870 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day.
52 yrs. 9 mos. 3 ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. John Victor Busse

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Bernadina Thoman

13-BIRTHPLACE OF MOTHER. (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Willenburg (son)

(Address) Harford & Grove Aves.

15-JUN 7-1923 Filed 192.

ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 5/23 -8 A.M. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Exhaustion- due probably to pulmonary congestion or oedema. (Accidentally fell from wharf at Broadway & Thames St., into harbor. (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) on June 4th./23/ 11.15 P.M.

(Duration) yrs. mos. ds.

(Signed) J. S. Mace. M. D. (Coroner.)

6/7/23 192. (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Holy Redeemer Cem 6/8 19 23

20-UNDERTAKER. ADDRESS

George J. Ruth 1735 Harford Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—1-10-21—M&T—1500 Bks.

164034
D76491

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76491

CERTIFICATE OF DEATH.

X 135

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 1

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Dr. George D. Bliss

(a) RESIDENCE No. 506 Washington St. ST., Dorchester Boston Mass. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 9, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	67	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mass.

PARENTS

10 NAME OF FATHER Cyrus W. Bliss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Hanna Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 JUN 7 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1923

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1923 to June 7, 1923.

that I last saw him alive on June 7, 1923

and that death occurred, on the date stated above, at 8.20 a.m.

The CAUSE OF DEATH* was as follows:

Post operative shock and hemorrhage following Operation

(duration) yrs. 1 mos 5 days

CONTRIBUTORY (Secondary) Paralysis for 3 mos

Prostatic hypertrophy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 6, 1923

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. W. Scott, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dorchester Boston Mass

DATE OF BURIAL June 7, 1923

20 UNDERTAKER Henry Hankins & Son Co

ADDRESS Edward Mc Gold Jr

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should indicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76492

D76492

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 Pennington ~~Ave~~ St. 25 WARD) X 1

2-FULL NAME Good

(a) RESIDENCE NO. 7026 Lexington ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7-1923

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Curtis Bay Balto

PARENTS

10 NAME OF FATHER Lester Good

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ella Parks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Lester Good

(Address) Curtis Bay Balto

15 JUN 7-1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1923

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1923, to June 7, 1923

that I last saw h alive on June 7, 1923

and that death occurred, on the date stated above, at 7.25 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

4½ to 5 months

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon D. Hoffman, M. D.

(Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health.

JUN 7-1923

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76493 ✓ D76493

CERTIFICATE OF DEATH.

161-601

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 Pennington St., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Good XX 2

(a) RESIDENCE NO. 1026 Pennington ST., 25 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): June 7-1923

7 AGE: Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Curtis Bay Balto

PARENTS

10 NAME OF FATHER Lester Good

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ella Parks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Lester Good
(Address) Curtis Bay Balto

15 Robert P. harrison, Registrar
Burial Permit Clerk.

JUN 7-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1923

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1923, to June 7, 1923, that I last saw him alive on June 7, 1923, and that death occurred, on the date stated above, at 7 00 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth
4½ to 5 month

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon L. Jones, M. D.

June 7 1923 (Address) Curtis Bay Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

JUN 7-1923

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76494

CERTIFICATE OF DEATH.

58-901 D76494

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., (WARD) 8

2-FULL NAME Clark Benson

(a) RESIDENCE NO. Nursery & Childs ST., Hosp. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 4 - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Chas. Benson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Rose Fair

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address)

15 Filed 6/7 1923 Robert F. Harrison, 1923 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1923

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1923 to June 4, 1923, that I last saw him alive on June 4, 1923, and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Primary anaemia. (Pernicious) not known
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diph. carrier (duration) — yrs. 1 mos. 11 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? yes.

What test confirmed diagnosis? Blood.

(Signed) B Macfarland MD, M. D.

(Address) Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL DATE OF BURIAL 6/7-1923

20 UNDERTAKER Commissioner Health. ADDRESS

6. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

348 6/7-1923

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76495

CERTIFICATE OF DEATH.

D76495

1-PLACE OF DEATH U.S.V. Hosp. #56,

CITY OF BALTIMORE: (No. Ft. McHenry, Md. ST., 24 31 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles C. Sullivan,

(a) RESIDENCE NO. Bloomington, Md. Garrett, Co. ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of or] WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal miner

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer -----

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Hospital Records
(Address) Ft. McHenry, Md.

15 Filed Aug 7-1923, 19.. Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from August 8, 1921, 19.. to June 6, 1923, that I last saw him alive on June 6, 1923, and that death occurred, on the date stated above, at 4:15 P.M. a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis active; Tuberculosis of the joints of lower extremities

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous joint abscesses

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Army Service

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) H. W. Barker, Surgeon R. , M. D.

6/7/23 (Address) U.S.V. Hosp. #56, Ft. McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Piedmont W. Va

DATE OF BURIAL June 7 1923

20 UNDERTAKER A. Zimmer & Bro

ADDRESS 1127 E. Baltimore St

MARGIN RESERVED FOR BINDING

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76496

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76496

CERTIFICATE OF DEATH.

99-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 Edmondson Ave St.) (17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Jones

(a) RESIDENCE NO. 714 Edmondson Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widow

5a ~~Married, Widowed, or divorced~~ HUSBAND of ~~WIFE~~ of: John. J. Jones

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Antrim Ireland

PARENTS

10 NAME OF FATHER: John. McCann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): John. A. Jones 714 Edmondson Ave

15 JUN 7 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1923

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1923 to June 6, 1923

that I last saw h~~e~~ alive on June 5, 1923

and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Irene Brown, M. D.

6/6, 1923 (Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 6-8 1923

20 UNDERTAKER: H. C. Brammer Son — ADDRESS 5171 Belair Rd

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D76497

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76497

CERTIFICATE OF DEATH.

Registered No. C 185

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hall annex Guilford Av. St., near Lexington Ward)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Burgess

(Residence in Baltimore: No. 45-5-W. Mulberry St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col.

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: (Month) (Day) (Year)

7-AGE: 41 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work: Rigger

(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country): Md

PARENTS

10-NAME OF FATHER: Chas. Burgess

11-BIRTHPLACE OF FATHER. (State or Country): ?

12-MAIDEN NAME OF MOTHER: E. Ellen - ?

13-BIRTHPLACE OF MOTHER. (State or Country): ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. John Burgess

(Address) 45-5-W. Mulberry

15- Robert P. Harrison, 192

Burial Permit Clerk. Registrar.

JUN 7 - 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: June 5 192 2 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry) thereon and from the evidence obtained by said Inquest, and Dr Geary (Inquest or Inquiry), find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract skull accidentally from roof -

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] (Coroner) M. D.

June 5 1923 (Address) 165 [illegible]

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents): At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Auburn Md. DATE OF BURIAL: 6-8-23

20-UNDERTAKER: Wm. Eaton ADDRESS 776 Lemmon

Spec—12-23-21—E.B.R.S.—400 Blks.

Dr Carman 1701 N Caroline

D76498

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D76498

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE; (No. 516 Park Ave St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard H. League

(a) Residence No. 1615 Light St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? 15yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-If married, widowed, or divorced HUSBAND of (or) WIFE of: Louise League

6-DATE OF BIRTH (month, day and year): April 8.

7-AGE. 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Ship Caller

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Thos. H. League

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Clara V. Lemon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md

14- (Informant): Louise League

(Address): 1615 Light St

15- Filed: Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 6 1923

17- I HEREBY CERTIFY, That I attended deceased from May 2, 1923, to June 6, 1923, that I last saw him alive on June 6, 1923, and that death occurred, on the date stated above, at 3.30 P.

The CAUSE OF DEATH* was as follows:

Mitral Murmur, Chronic Interstitial Nephritis Uraemia uraemic coma

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Murmur & Nephritis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? N.A. Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Microscopic examination

(Signed) R. P. Carman, M. D.

6-7-, 1923 (Address) 1701 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park DATE OF BURIAL: June 8, 1923

20-UNDERTAKER: W. M. Cook ADDRESS: 502 E North

JN 7 1923

U. S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING — NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76499 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76499

CERTIFICATE OF DEATH.

139

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1818 W. Saratoga ST., 19 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret S. Rayme

(a) RESIDENCE NO. 1818 W. Saratoga ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 3 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles M. Rayme

6 DATE OF BIRTH (month, day, and year): Feb. 20 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	3	16	

8 OCCUPATION OF DECEASED: Home

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Andrew M. Tilmon

11 BIRTHPLACE OF FATHER (city or town) (State or country): At Sea

12 MAIDEN NAME OF MOTHER: Theresa Albright

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Chas. M. Rayme 1818 W. Saratoga St

15 Filed 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1923, to June 6, 1923, that I last saw h[illegible] alive on June 5, 1923, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Uterine Fibroid.

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Edema Of Legs

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Abdominal Op

(Signed) J. M. Lundquist M. D.

19 (Address) 826 N. Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem

DATE OF BURIAL: June 8 1923

20 UNDERTAKER: Wm. Pickrell & Son

ADDRESS: North Ave.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76500 ✓ 161-001 D76500

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Sterling

(a) RESIDENCE NO. Dale, Md ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female — 4 COLOR OR RACE White — 5 Single, Married, Widowed, or Divorced, (write the word) ✓

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) June 5, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Mathiot Sterling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Miriam Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant W W Gray

(Address) Johns Hopkins Hospital

15 JUN 7-1923 Robert P. Harrison, .19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1923, to June 7, 1923, that I last saw her alive on June 7, 1923 and that death occurred, on the date stated above, at 1.30 A.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of ...

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) W.W. Gray, M. D.

.19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sollston Md. — DATE OF BURIAL June 8 1923

20 UNDERTAKER W. J. Tickner Sons — ADDRESS North Penn St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76501

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

145-001
145 D76501

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. E. Monument ST., 15 WARD)

2-FULL NAME Mrs Emma Soulsby

(a) RESIDENCE No. 3329 Alto ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 20 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 2-1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~38~~	38	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm Yates Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Nina Lygotta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Robert H. Soulsby
(Address) 3329 Alto Ave.

15 Filed JUN 7-1923 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1923

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to June 6, 1923,

that I last saw her alive on June 6, 1923

and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) 9 yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-3-23

Was there an autopsy? No Postmortem Section

What test confirmed diagnosis?

(Signed) Ernest Edlavitch, M. D.

6-6, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 6-8 1923

20 UNDERTAKER W. J. Tickner Sons

ADDRESS North & Penna Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Caesarean Section

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76502

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76502

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 Burgundy ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ira Chatterton

(a) RESIDENCE NO. 932 Burgundy ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomy Chatterton

6 DATE OF BIRTH (month, day, and year): Sept 4-1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: artist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Enfield Chatterton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mt Vernon

12 MAIDEN NAME OF MOTHER: Hannah Hanaty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mt Vernon

14 Informant: Thomy Chatterton

(Address) 932 Burgundy St

15 JUN 7-1923 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 26. 1923. to June 7. 1923.

that I last saw him alive on June 7. 1923 and that death occurred, on the date stated above, at 2 40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no. Date of —

Was there an autopsy? no. Physical Exam.

What test confirmed diagnosis?

(Signed) Chas. Conkon, M. D.

June 6, 1923 (Address) 888 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A. G. Cem — DATE OF BURIAL: 6-8 1923

20 UNDERTAKER: James Degnan & Son — ADDRESS: 100 Saco St.

WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD.

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D76503

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76503

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1823 Riggs Ave. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah R. Russell

(Residence in Baltimore: No. 1823 Riggs Ave. St.; yrs. 37 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. about 1879
(Month) (Day) (Year)

7-AGE. 44 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housewife at
(b) General nature of industry, business, or establishment in which employed (or employer). Home

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Mathew Mc Gee

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Sarah Reed

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred B. Russell

(Address) 1823 Riggs Ave.

15- Robert P. Harrison
JUN 7 1923 192 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 6th 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) no history

(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.
(Coroner.)

June 6 1923 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Louden Park Cem. DATE OF BURIAL. June 8 1923

20-UNDERTAKER. Joseph L. Cook ADDRESS 1003 N. Balto St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76504

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76504

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 Linden Ave ST., 14 WARD)

2-FULL NAME Ada Amelia Kennard

(a) RESIDENCE NO. 1701 Linden Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 5 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 17, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER William H. Kennard

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Virginia C. Greiner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Florence Kennard
(Address) 1701 Linden Ave

15 JUN 8 - 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1923

17

I HEREBY CERTIFY, That I attended deceased from , 1910 , to June 7 , 1923 ,
that I last saw h-s alive on June 7 , 1923 ,
and that death occurred, on the date stated above, at 5:30 p. m.
The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

Over
(duration) 13 yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. T. Kemp , M. D.
, 19 (Address) St James Apartment

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	June 7 1923
20 UNDERTAKER Addie M. Mather	ADDRESS 723 W Lafayette Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

D76505

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76505

CERTIFICATE OF DEATH.

Registered No. 31

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Brown

(a) Residence No. 122 W. Hughes St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Black	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1878

7-AGE. 44 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Calvert Co., Md.

PARENTS.

10-NAME OF FATHER. Virgil Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Calvert Co., Md.

12-MAIDEN NAME OF MOTHER. Sally Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Calvert Co., Md.

14- (Informant) Municipal Hospital Records

(Address)

15-

Filed JUN 8-1923 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 6, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 18 1923 to June 6 1923 that I last saw him alive on June 5 1923 and that death occurred, on the date stated above, at 2:10 A.M.

The CAUSE OF DEATH* was as follows:

Pott's Disease of Spine

(Duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous pneumonia

(Duration) yrs. 10 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. M. Shipley, M. D

6-6-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Woodlawn	June 9 1923
20-UNDERTAKER.	ADDRESS
E. B. Brown & Son	108 W. Monto-

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76506

CERTIFICATE OF DEATH.

D76506

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. The Cecil Apartments ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis P. Reitz.

(a) RESIDENCE NO. The Cecil Apartments. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? --- yrs. --- mos. --- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) November 3rd. 1845.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	77	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Glass Manufacturer.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Lewis Reitz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine ---

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Charles L. Reitz. (nephew)

(Address) The Cecil Apartments.

15 JUN 8 - 1923 ROBERT R. KRAUTER, Registrar.

JUN 8 - 1923 Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7th. 1923

17 I HEREBY CERTIFY, That I attended deceased from April 14th 1923. to June 7th. 1923.

that I last saw him alive on June 6th. 1923.

and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the Heart.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of the prostate & bladder. (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ---

Did an operation precede death? No. Date of ---

Was there an autopsy? No.

What test confirmed diagnosis? Clinical diagnosis.

(Signed) Otto M. Reinhardt, M. D.

6/7. 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park cem.

DATE OF BURIAL: June 9 1923

20 UNDERTAKER: Chas. E. Franck

ADDRESS: 502 Park Ave.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76507

CERTIFICATE OF DEATH.

3 D76507

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 ais gunth st ST., 10 WARD)

2-FULL NAME Morris Kohn

(a) RESIDENCE No. 713 ais gunth st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eva Kohn

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 50 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer): [redacted]

(c) Name of employer: [redacted]

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Zalman Kohn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Levis (Address): 1439 E Balto st

15 Filed JUN 8 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7 1923

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1923 to June 7, 1923

that I last saw h[illegible] alive on June 7, 1923

and that death occurred, on the date stated above, at 8.20 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

(duration) [illegible] yrs. mos. ds.

CONTRIBUTORY (Secondary): Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 2731 Portsmouth

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: June 8 1923

20 UNDERTAKER: Josh Levis — ADDRESS: 1439 E Balto st

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76508

CERTIFICATE OF DEATH.

17 D76508

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital Rutland & Monument St. ST. 70 WARD)

2-FULL NAME Mr. Ruben Seidel

(a) RESIDENCE NO. 508 S. Pulaski St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Seidel

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE: Years 57 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris Seidel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Fannie Seidel

(Address) 1439 Eutaw St

15 JUN 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1923, to June 7, 1923, that I last saw him alive on June 7, 1923 and that death occurred, on the date stated above at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) acute appendicitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 29, 1923

Was there an autopsy? No Appendectomy.

What test confirmed diagnosis?

(Signed) Adler Spudheimer M. D.

June 7th, 1923 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mach R. DATE OF BURIAL June 8 1923

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eutaw

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76509 34

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-001 D76509

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 28 (WARD)

2-FULL NAME Rebecca Sacks

(a) RESIDENCE No. 4 Bruce George ST., Windsor Hills WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	—	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Philip

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Mary E. Brodie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUN 8 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1923

17

I HEREBY CERTIFY, That I attended deceased from June 3rd, 19 23 to June 7th, 19 23, that I last saw h[illegible] alive on June 5th, 19 23, and that death occurred, on the date stated above, at 11 40 a. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus. obstructive

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of June 6 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) J. L. Reichert, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrersburg Pa DATE OF BURIAL June 8, 19 23

20 UNDERTAKER Jack Lewis ADDRESS 1437 Eutaw

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76510

CERTIFICATE OF DEATH.

129 D76510

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 247 S. Highland Ave WARD) 26

2-FULL NAME Mary A. F. Sinclair

(a) RESIDENCE No. 247 S. Highlands St Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 28-1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) House-work

(c) Name of employer same. Home.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. H. Sinclair

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Louisa Barker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Louisa Sinclair

(Address) 247 S Highland Ave

15 Filed JUN 8-1923 Robert R. Forster Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1923 to June 6 1923

that I last saw her alive on June 6. 1923

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

Heart exhaustion

(duration) X yrs. X mos. 14 ds.

CONTRIBUTORY (Secondary) Chronic Brights Disease (duration) X yrs. 6 mos. X ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Jas L. Friedenwald, M. D.

June 19 23 (Address) 248 So 30 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	June 8 1923
20 UNDERTAKER	ADDRESS
H. Sander's Sons	1710 Flat St.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76511

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D76511

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 N. Mount ST. 19 WARD)

2-FULL NAME Serena Hayes (Luffman)

(a) RESIDENCE NO. 302 N Mount ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: Colrd | 5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Luffman

6 DATE OF BIRTH (month, day, and year): Feb 1884

7 AGE: 39 Years 1 Months — Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 0 7 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): md

PARENTS

10 NAME OF FATHER: Joseph Zacherman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Ellen Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant (Address): Joseph Hayes 302 n mount st

15 Filed JUN 6 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 5, 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1923. to June 5, 1923.

that I last saw her alive on June 5, 1923,

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy (Cerebral)

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary): Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

19 (Address) 1118 Druid Hill Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: mt auburn cemetery | DATE OF BURIAL: Jun 9 1923

20 UNDERTAKER: John H Feddrin | ADDRESS: 1142 Hilen st

Spec.—1-10-21—M&T—1500 Bks.

D76512

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 D76512

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 322 N. Pearl ST., 4 WARD)

2-FULL NAME Rosa Secola (Ciccona)

(a) RESIDENCE NO. 322 N Pearl ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 13—22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md. (Ciccona)
(State or country)

PARENTS

10 NAME OF FATHER Tony Secola

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Mariaghis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Tony Secola
(Address) 322 N Pearl St

15 JUN 8-1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 6th, 1923, to June 7th, 1923,

that I last saw h[er] alive on June 6th, 1923,

and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Excessive Heat for
1 disposing Malnutrition

(duration) — yrs. Un known mos ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of — — —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William F Drew, M. D.

, 19 (Address) 1742 Woodland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	June 8 1923
20 UNDERTAKER	ADDRESS
H. M. Routson	2238 N Monta

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76513

CERTIFICATE OF DEATH.

43 ✓ D76513

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital. ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Hess

(a) RESIDENCE NO. 922 Ryan St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labored

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 JUN 8 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1923

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1923, to June 7, 1923, that I last saw him alive on June 6, 1923, and that death occurred, on the date stated above, at 8:00 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) (Terminal) Broncho-Pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) H. M. Powell, M. D.

6-7-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friendship Addition	June 8 1923

20 UNDERTAKER W. J. Pickney & Sons North & Mt. Ave. ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D76514 — REGISTERED No. D76514

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 S. Monroe. ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Boland.

(a) RESIDENCE NO. 606 S. Monroe. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	63	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Blacksmith.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Otis Boland.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Bridget Laiberty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Viola Bossom. (Address) 606 S. Monroe St.

15 JUN 8-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1923

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1923, to June 6, 1923, that I last saw him alive on June 6, 1923, and that death occurred, on the date stated above, at 11 1/2 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Endocarditis.

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) ...yrs. ... mos. 1 ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robert C Kitch M. D.

6/8, 1923 (Address) 215 Holliday

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery.	June 9th 1923

20 UNDERTAKER: Wm J Hartwell. ADDRESS 2236 W. Baltimore St

Spec—12-23-21—E.B.R.S.—400 Blks.

Dr. Gordy
4218 Hokford Rd.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76515

D76515

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 502 E. Thirtieth St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Dora Morrow

(a) Residence No. 502 E. Thirtieth St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced ~~Husband~~ of (or) WIFE of Henry Morrow

6-DATE OF BIRTH (month, day and year) Aug. 14 1854

7-AGE, 68 yrs. 9 mos. 23 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), South Carolina

PARENTS.

10-NAME OF FATHER, John E. Dickson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), South Carolina

12-MAIDEN NAME OF MOTHER, Nancy Stallings

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), South Carolina

14- (Informant) Henry Morrow
(Address) 502 E. 30th St.

15- Filed JUN 8-1923 ROBERT R. KRAUTER, Registrar.
~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 6-1923

17- I HEREBY CERTIFY, That I attended deceased from Nov 1st 1922 to June 6th 1923

that I last saw h.. alive on June 6th 1923

and that death occurred, on the date stated above, at 10 50 A m.

The CAUSE OF DEATH* was as follows:

Cancer of mouth.

(Duration) yrs. 11 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic

(Signed) L. L. Gordy, M. D.

June 7, 1923 (Address) 4218 Hokford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, London Park — DATE OF BURIAL, 6/8/1923

20-UNDERTAKER, Wm. Cook — ADDRESS 502 E. North Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

D76516

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76516

CERTIFICATE OF DEATH.

1574-061

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Charles & Lemmuel St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Blaze

(Residence in Baltimore: No. 2019 N. Bruce St.; yrs. 43 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Col'd	Married

6-DATE OF BIRTH. 1852
(Month) (Day) (Year)

7-AGE. 71 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or. ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country). Md.

PARENTS.

10-NAME OF FATHER. David Blaze

11-BIRTHPLACE OF FATHER. (State or Country). Md

12-MAIDEN NAME OF MOTHER. Hurreta Blanken

13-BIRTHPLACE OF MOTHER. (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. Blaze

(Address) 2019 N. Bruce

15-

FILED JUN 8 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 6 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

Duration ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
(Coroner)

Jun 7 1923 (Address) 1639 Bruce

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Zion Cem	June 8 1923

20-UNDERTAKER. [illegible] ADDRESS 111 N.

Brown Fleland & Schroeder

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76517

CERTIFICATE OF DEATH.

89 D76517

REGISTERED NO.

1-PLACE OF DEATH Preston Apartments

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harrison Cassard

(a) RESIDENCE NO. Preston Apts. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 1 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Walker Cassard

6 DATE OF BIRTH (month, day, and year) May 3 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
53	53	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No occupation

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Louis R. Cassard

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Eliza H Kensett

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Louise W. Cassard
(Address) Preston Apts

15 JUN 8 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1923

17 I HEREBY CERTIFY, That I attended deceased from May 27 - 1923 to June 6 - 1923.

that I last saw him alive on June 6 - 1923.

and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? None —

(Signed) Otho W. Lamed — M. D.

June 9 - 1923 (Address) 132 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	June 8 1923
20 UNDERTAKER	ADDRESS
Henry J. Jenkins Sons Co	McCulloh & Orchard Sts.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76518

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

14-001 D76518

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor, 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Simmering

(a) Residence No. Poulton Valley Ave. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single~~ ~~Married~~ Widowed, ~~or Divorced~~ (Write the word) Widow

5a-If married, widowed, ~~or divorced~~ HUSBAND ~~or WIFE~~ of Mrs. Simmering

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 64 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Thomas Shriver

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Elizabeth Kramer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-

(Informant) Sister Superior

(Address) Poulton & Valley Sts

15-

JUN 8-1923 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 7 1923

17- I HEREBY CERTIFY, That I attended deceased from No record 19.... to .... 19....

that I last saw h[illegible] alive on June 5 1923

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

Duration 1 week

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

June 7 (Signed) F. A. Warner, M. D.

1923 (Address) 1133 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Western	6-9, 1923
20-UNDERTAKER,	ADDRESS
E & B Hark	116 E Mad St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Missing

#D76519

N. B.—WRITE PLA
should be car
in plain term
instructions o

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Sister Florence

(Address) Preston St Baltimore Md

15- Filed JUN 8 - 1923 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Western — DATE OF BURIAL: 6-9 19 20

20-UNDERTAKER: E & B Hearse — ADDRESS: 1126 E Mad 8

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76520 — 90 D76520 REGISTERED NO.

D76520

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 931 Lindenave ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Murray

(a) RESIDENCE. NO. 931 Lindenave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Murray

6 DATE OF BIRTH (month, day, and year) Aug 1-1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer Hamond & Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Marion L. Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Marion Murray (Address) 931 Lindenave

15 Filed JUN 8-1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1923

17 I HEREBY CERTIFY, That I attended deceased from May 26. 1923. to June 6. 1923.

that I last saw him alive on June 5. 1923.

and that death occurred, on the date stated above, at 2.15 a. m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) N. C. Pittman, M. D.

(Address) 817 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 6/8 23

20 UNDERTAKER: Samuel Hemsley — ADDRESS: 1178 Bid

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause Unknown.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100201

D76521 REGISTERED NO.

D76521 PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp 10 ST. 1 WARD)

2-FULL NAME Mrs Rose Ridgl

(a) RESIDENCE NO. 741 Forrest ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 7 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): Oct 12 1873

7 AGE: 49 Years | 7 Months | 26 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Joseph Kennedy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Rosie McNally

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: House John J. Ridgl

(Address): 741 Forrest St

15 JUN 8 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1923, to June 7, 1923.

that I last saw her alive on June 6, 1923.

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & L.

(Signed) John J. Kruger M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: June 9'23

20 UNDERTAKER: Edmund W. Conklin — ADDRESS: 324 E Eag

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS SPACE MUST NOT BE WRITTEN IN. PHYSICIAN should be careful to see that every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be necessary. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76522
1-PLACE OF DEATH

34 D76522
REGISTERED NO.

CITY OF BALTIMORE: No 4308 Eden ST.: 3 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Smith

(a) RESIDENCE. No. 430 S Eden ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Peter E Smith

6 DATE OF BIRTH (month, day, and year): April 10 1876

7 AGE — Years: 47 Months: 1 Days: 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Peter Smith
(Address) 430 S Eden

15 Filed JUN 8 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7 1923

17 I HEREBY CERTIFY, That I attended deceased from May 11 1923 to June 7 1923 that I last saw h in alive on June 6, 1923 and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis — ? .

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E L Cassard, M. D.

6.7.23. 19 (Address) Govans Hills.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents

DATE OF BURIAL: June 9 1923

20 UNDERTAKER: Wendell P Appel & Son

ADDRESS: 378 N

N. B.—WRITE PLAINLY. WITH INK. All information should be stated EXACTLY. PHYSICIANS should carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may CAUSE OF DEATH is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D76523 — 128 — D76523

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE (No. 644 So. 13th St. Ward) 26

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ivay P. Haase (Haas)

(Residence in Baltimore: No. 644 So. 13th St., (yrs.) 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Divorced

6-DATE OF BIRTH: June (Month) 21st (Day) 1881 (Year)

7-AGE: 41 yrs. 11 mos. 16 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Ohio

PARENTS:

10-NAME OF FATHER: John Denny

11-BIRTHPLACE OF FATHER, (State or Country): Ohio

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS CORRECT TO THE BEST OF MY KNOWLEDGE.
(Informant) John F. Haase
(Address) 7 E. Henrietta St

15- JUN 8 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: June (Month) 6th (Day) 192.3 (Year)

17- I HEREBY CERTIFY that I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) Thos. B. Horton M. D.
Coroner.

June 8th 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Ruled Out

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: June 9 192.3

20-UNDERTAKER: John F. Denny — ADDRESS: 715 Light St

D76524

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 188-003

D76524 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence E. Weber

(Residence in Baltimore: No. 2717 Eastern Ave. St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Unless it is stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	

6-DATE OF BIRTH. Sept. 13/25 1913
(Month) (Day) (Year)

7-AGE. 9 yrs. 8 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School- girl
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. John Weber

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Catherine Ziegel

13-BIRTHPLACE OF MOTHER. (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Weber

(Address) 2717 Eastern Ave.

15- JUN 8 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 4/23 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Accidental) Struck by automobile Fractured Skull- rt. leg & rt hip joint. (Inquest to be held June 6/23 8.30 P.M. Eastern Police Station) ds.
(Duration)

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. S. Wallen M. D.
(Coroner)

6/6/23 192.... (Address) 5pi E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Oaklawn DATE OF BURIAL. June 8 1923

20-UNDERTAKER. Pinkler & Pinkler ADDRESS 1734 Eager

Spec.—1-10-21—M&T—1500 Blks.

D76525 HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D76525

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST., WARD)

2-FULL NAME David A. J. Krug

(a) RESIDENCE NO. 3017 Fait ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS PERMANENT RECORD. PHYSICIANS should take CARE that every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catharine Krug

6 DATE OF BIRTH (month, day, and year) Dec 25 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	38	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER H. Krug

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER L. E. Sentz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unk.

14 Informant Catharine Krug.

(Address) 3017 Fait ave

15 Filed JUN 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Octob. 31, 1921, to June 5, 1923, that I last saw him alive on June 5, 1923 and that death occurred, on the date stated above, at 920 p. m.

The CAUSE OF DEATH* was as follows:

General Paralysis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? Unk.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinic & Laboratory

(Signed) A. J. Krug M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery

DATE OF BURIAL June 8 1923

20 UNDERTAKER Zirkler + Zirkler

ADDRESS 1739 E. Eager St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

D76526 HEALTH DEPARTMENT—CITY OF BALTIMORE D76526

CERTIFICATE OF DEATH. 6 700-001 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 229 N. Durham St., ... Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Calvert Lee Brown

(Residence in Baltimore: No. 229 N. Durham St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If [illegible] state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (write the word.)
male	black	single

6-DATE OF BIRTH. Sept. 9/1922 (Month) (Day) (Year)

7-AGE. 7 yrs. ..... mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Ernst Brown

11-BIRTHPLACE OF FATHER, (State or Country). King & George Co. Va.

12-MAIDEN NAME OF MOTHER. Lillian Champ

13-BIRTHPLACE OF MOTHER, (State or Country). Percy William Co. Va. County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillian Brown

(Address) 229 N. Durham St.

15- JUN 8 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 6/23 (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Primary Bronchopneumonia

(Duration) .....yrs. .....mos. 3 ds.

CONTRIBUTORY (Secondary) (Duration) .....yrs. .....mos. .....ds.

(Signed) J. S. Potter M. D. (Coroner.)

6/7/23 192.... (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Asbury Cem. DATE OF BURIAL. 6/9th 1923

20-UNDERTAKER. Jas. M. Atkinson ADDRESS 1625 E. Preston St

Spec—12-23-21—E.B.R.S.—400 Blks.

D76527 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D76527

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Little Sisters of the Poor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Margaret Bridges

(a) Residence No. Preston Valley Ho St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Bridges.

6-DATE OF BIRTH (month, day and year) Jan. 1839.

7-AGE. 84 yrs. 5 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER. Michael Ekez.

11-BIRTHPLACE OF FATHER (city or town) (State or Country).

12-MAIDEN NAME OF MOTHER. Ann Greenwell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14-

(Informant) Sister Florence

(Address) Preston & Valley

15-

Filed JUN 8 - 1923 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 6 1923

17- I HEREBY CERTIFY, That I attended deceased from ~~to~~ record ..... 19..... to ..... 19.....

that I last saw her alive on June 5 19 23

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

June 7 (Signed) F. A. Werner M. D

, 19 23 (Address) 1123 Valley St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral DATE OF BURIAL. June 9 — 19 23

20-UNDERTAKER. H. C. Wiedefeld ADDRESS 914 Greenmt Ave

N. B.—WRITE PLAINLY, WITH INK. ~~All~~ should be carefully supplied. AGE should be stated EXACTLY. ANSWERS in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76528

116-005

D76528

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John M. Bossman

(a) Residence No. Bay View Asylum. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1862

7-AGE. 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. John F Baumann

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Catherine Edel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Municipal Hospital Records

(Address)

JUN 8 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 7, 1923

17- I HEREBY CERTIFY, That I attended deceased from October 21 1921 to June 7, 1923 that I last saw him alive on June 6, 1923 and that death occurred, on the date stated above, at 5:45 A.M.

The CAUSE OF DEATH* was as follows:

Senility

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Immed) (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H M Powell M. D.

6-8- 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Oak Lawn Cemetery	June 9 1923
20-UNDERTAKER.	ADDRESS
Henry Houck & Son	1301 E Eager St

R. B. WHITE & CO., Baltimore. Entered ... should be stated EXACTLY. PHYSICIAN ... should be carefully supplied. AGE should be stated ... in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76529

91-09 D76529

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 N. Central Ave ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Schulz

(a) RESIDENCE NO. 1011 N. Central Ave ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 4 mos. 21 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Annie C. Schulz

6 DATE OF BIRTH (month, day, and year) Dec. 17 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John B. Schulz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Magdelena Lang

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Joseph Schulz (Address) 1011 N. Central Ave

15 JUN 8 - 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1923

17 I HEREBY CERTIFY, That I attended deceased from May 15 1923 to June 7th 1923

that I last saw him alive on June 7th 1923

and that death occurred, on the date stated above, at 6 55 A m.

The CAUSE OF DEATH* was as follows:

Uremia Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. L. Elser M. D.

, 19 (Address) 1130 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Noble Redeemer Cemetery — DATE OF BURIAL June 11 1923

20 UNDERTAKER Henry Hoeck Son — ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be careful to see that AGE is correctly supplied. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76530

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76530

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1 Bay View St., 7 172 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Antony Dorb

(Residence in Baltimore: No. 709 N. Belnord Ave. St.; 30 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Unknown 1.....
(Month) (Day) (Year)

7-AGE. about 42 yrs. ... mos. ... ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Bohemia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dore Grb

(Address) 709 N Belnord Ave

15- FILED JUN 8 - 1923 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 7th 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, in ....thereof that said deceased came to.. death (opsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(Duration) ... yrs. ... mos. ... ds.

Suicide - jumped out 2nd Story window of Home

(Duration) ... yrs. ... mos. ... ds.

(Signed) Chas B. Norton M. D.
Coroner.

June 8th 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Balto. Md

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Oak Hill

DATE OF BURIAL. June 10 1923

20-UNDERTAKER. Jas X Bradley

ADDRESS 1906 W Lexington

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Also state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76531

CERTIFICATE OF DEATH.

80 D76531

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2208 Essex St St.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth McElhinney

(Residence in Baltimore: No. 2208 Essex St St.; yrs. ..... mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. June 5th 1923 (Month) (Day) (Year)

7-AGE. 0 yrs. 0 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. J. L. McElhinney

11-BIRTHPLACE OF FATHER. (State or Country). Md

12-MAIDEN NAME OF MOTHER. Albina Dudeck

13-BIRTHPLACE OF MOTHER. (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. L. McElhinney

(Address) 2208 Essex St.

15- JUN 8 - 1923 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH, June 7th 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and (autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. B. Fenton M. D.
(Coroner)

June 7 1923 (Address) Curtis Bay, Balto

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer DATE OF BURIAL. June 8 1923

20-UNDERTAKER. Funk & Crowlson ADDRESS 1706 Eastern

Spec—12-23-21—E.B.R.S.—400 Bks.

D76532 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D76532

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Mullen

(a) Residence No. Preston Valley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed or Divorced~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE Yrs. About 75 years Mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Patrick Mullen

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER, Katie Gallagher

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

11- (Informant) Sister Florence

(Address) Preston & Valley

18- JUN 8 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 7 1923

17- I HEREBY CERTIFY, That I attended deceased from ~~19~~ to ~~19~~ 19..... that I last saw h. alive on June 3 1923, and that death occurred, on the date stated above, at 6.40 P.m. The CAUSE OF DEATH* was as follows:

Valvular disease of heart.

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? F. A. Warner, M. D.

(Signed)

June 7, 1923 (Address) 1103 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer DATE OF BURIAL. June 9, 1923

20-UNDERTAKER. William G. Schaffrath ADDRESS 1816 Monument

N. B.—Items must be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76533

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D76533

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 905 Ninth St., Orangeville 16 WARD)

2-FULL NAME Joseph H. Carrick

(a) RESIDENCE NO. 905 Ninth ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret M. E. Carrick

6 DATE OF BIRTH (month, day, and year) Oct 17-1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	73	7	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) Md Steel Co
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS
10 NAME OF FATHER William Carrick
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Mary Powers
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Etta M. Morgan
(Address) 905 Ninth St.

15 JUN 8 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. V- 1922 to June 6 1923,
that I last saw him alive on June V- 1923,
and that death occurred, on the date stated above, at 8 a. m.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ortho of Lungs (duration) ? yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Wm. J. Schmidt, M. D.
6/7. 1923 (Address) 701 N Kelwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. | DATE OF BURIAL 6/9 1923

20 UNDERTAKER Chas Powers & Son ADDRESS 1810 W Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S ... should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPA-mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76534

CERTIFICATE OF DEATH.

100-001

REGISTERED NO. D76534

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hosp ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Hood.

(a) RESIDENCE NO. 2106 Boone St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed or divorced HUSBAND of Mary E. Hood

6 DATE OF BIRTH (month, day, and year) Feb. 6, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	54	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Francis J. Hood

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co Maryland

12 MAIDEN NAME OF MOTHER: Sophia Eddard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md

14 Informant: Mrs Chas. Hood (Address) 2106 Boone St

15 JUN 8 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1923

17 I HEREBY CERTIFY, That I attended deceased from April 2 1923. to June 6. 1923.

that I last saw him alive on June 6. 1923.

and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Recto-Vesical Fistula

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 4-4-23

Was there an autopsy? Not

What test confirmed diagnosis? S. P. S. and operation

(Signed) J. V. Fezenbeck, M. D.

, 19 (Address) St Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. DATE OF BURIAL: Jun 9 23

20 UNDERTAKER: A S Marshall ADDRESS: 3539 Falls Rd

N. B.—WRITE PLAINLY, WITH CONSIDERABLE DETAIL. AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76535

CERTIFICATE OF DEATH.

D76535

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 304 S. Furrow ST., 20 WARD)

2-FULL NAME Edgar H. Cavey

(a) RESIDENCE NO. 304 S. Furrow ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds.— How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 24, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	18	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William A. Cavey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Cecil Kilbaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) William A. Cavey 304 S. Furrow St.

15 Filed JUN 8 1923, 19 Robert P. Harrison; Registrar

Paul J. Leavitt, Clerk

N. B.—WRITE PLAINLY, WITH CARBON PENCIL. ALL questions should be stated EXACTLY. Information should be carefully supplied. Exact statement of OCCUPATION should be given. If DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION very important. See Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1923

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1923, to June 6, 1923, that I last saw h alive on June 6, 1923, and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows:

Heat Exhaustion

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Epilepsy (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clynical

(Signed) Howard Kahn, M. D.

6/8, 1923 (Address) [redacted] 2027 Wood St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Orba Lem	June 9 1923

20 UNDERTAKER Easton Sons ADDRESS Ellicott City

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76536 D76536

CERTIFICATE OF DEATH.

REGISTERED NO. 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 Warwick Ave ST., 15 WARD)

2-FULL NAME Helen Levene Hoffman

(a) RESIDENCE No. 1008 Warwick Ave St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. 8 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 25-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas F. Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Rosie S. Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Was. DC.

14 Informant Chas F. Hoffman

(Address) 1008 Warwick Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1923

17 I HEREBY CERTIFY, That I attended deceased from May 15 , 1923 , to June 7th , 1923.

that I last saw him alive on June 7 , 1923,

and that death occurred, on the date stated above, at 9:20 m.

The CAUSE OF DEATH* was as follows:

Pneumonitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) yrs. mos. 22 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. G. Smith , M. D.

6-8, 1923 (Address) 118 N Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. Randallstown Md DATE OF BURIAL June 9 1923

20 UNDERTAKER Harry W. Ehlen ADDRESS 1902 W. Mount Ave

Robert F. Garrison

JUN-1923 Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76537A

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76537

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 608 Brook Ave. (St.) Rockeburg (WARD) 6

2-FULL NAME Walter H. Kraft

(a) RESIDENCE NO. 411 N. Patterson Park Ave. (St.)

(Usual place of abode) WARD .....

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma V. Kraft

6 DATE OF BIRTH (month, day, and year) Aug 27th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Bakery

(c) Name of employer White Bakery Baltimore

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph A. Kraft

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia A. Shingle

13 BIRTHPLACE OF MOTHER (city or town) Lancaster Co (State or country) Pennsylvania

14 Informant George M. Krause

(Address) 608 Brook Ave. Rockeburg

15 Filed June 7 1923 Robert E. Merrifield Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to June 6, 1923, that I last saw him alive on June 6, 1923, and that death occurred, on the date stated above, at 8:05 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis Interstitial

(duration) yrs. mos. 6 ds.

Chronic Endocarditis, Bacterial

CONTRIBUTORY (Secondary) Hypertrophy (duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Chas B Lemmon, M. D.

6/6, 1923 (Address) 718 N Port Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery

DATE OF BURIAL June 9 1923

20 UNDERTAKER Fielder & Lassahn Sons

ADDRESS Fulkerton

JUNE 7 1923

Exact statement of occupation should be carefully supplied. Age should be properly classified. Exact statement of birthplace is necessary so that it may be properly classified. Information should be carefully supplied, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation should be carefully supplied. Age should be properly classified. Exact statement of birthplace is necessary so that it may be properly classified. Information should be carefully supplied, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See Instructions on back of certificates. See Instructions on back of certificates. See

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76538

D76538 CERTIFICATE OF DEATH. 118-002 REGISTERED NO.....

1-PLACE OF DEATH Church Home and Infirmary (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 25 ST., WARD)

2-FULL NAME Mrs. Hannah Underwood

(a) RESIDENCE NO. 414 Potomac Av. Brooklyn ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of George W. Underwood

6 DATE OF BIRTH (month, day, and year) Aug 25 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	48	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sweden

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sweden

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Geo. W. Underwood
(Address) 414 Potomac Ave Brooklyn

15 JUN 8 - 1923 , 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month) June (day) 7, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1923, to June 7, 1923,

that I last saw h[illegible] alive on June 7, 1923

and that death occurred, on the date stated above, at 1:30 P.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction, Acute

(duration) 1 yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary) / (duration) / yrs. / mos. / ds.

18 Where was disease contracted if not at place of death? / /

Did an operation precede death? yes Date of June 6, 1923

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Cayetano Parrottano M. D.

, 19 (Address) Church Home and Hsp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	June 9 1923
20 UNDERTAKER John F Denny	ADDRESS 715 Light

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76539

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76539

CERTIFICATE OF DEATH. X 34

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Claude Green

(a) RESIDENCE NO. 901 J. St., Sparrows Point, Md. ST., WARD Sparrows Pt. Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Sam Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Hannah Williamson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Municipal Hospital Records.
(Address)

15 JUN 8 - 1923, 19 Robert F. Garrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1923

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1923, to June 5, 1923, that I last saw him alive on June 4, 1923, and that death occurred, on the date stated above, at 9:15 A.M.

The CAUSE OF DEATH* was as follows: Pelvic Disease

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Secondary Anemia (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Pt. at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) C. M. Shiplup, M. D.

6-6-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	June 8 1923

20 UNDERTAKER John H. Denny ADDRESS 715 Light St

N.B.—WRITE PLAINLY, with ink. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully supplied. AGE should be properly classified

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76540 — CERTIFICATE OF DEATH. — 74-001 — D76540

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) Christs Institution Hospital ST., 10 WARD)

2-FULL NAME Hermon Seifert

(a) RESIDENCE NO. Benzies Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Elizabeth Seifert

6 DATE OF BIRTH (month, day, and year) Oct 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md

PARENTS
10 NAME OF FATHER Julius Seifert
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany
12 MAIDEN NAME OF MOTHER Wilhelmina Hans,
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr Adel Seifert
(Address) Benzies Md

JUN 8 Filed 1923 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1923

17 I HEREBY CERTIFY, That I attended deceased from June 5 - 1923. to June 7 - 1923.
that I last saw him alive on June 7 - 1923.
and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy
Bright Disease & Paralysis (duration) yrs. ..... mos 1 ds.
CONTRIBUTORY (Secondary) Bright Disease & Paralysis (duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? Benzies. Md.
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?
(Signed) D L W Kennard M. D.
67. 1923 Address) 708 Encon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1 St Germain	June 8 19 3
20 UNDERTAKER	ADDRESS
Peter Nicolaus	2068 Eastern Q

NOTE.—WRITE PLAINLY. All information should be carefully supplied. AGE should be given in years, months and days. Exact statement of OCCUPATION may be properly classified, so that it may be properly coded. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76541 ✓

D76541

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 Hampson ST., 14 WARD)

2-FULL NAME Baby Harrid

(a) RESIDENCE NO. 816 Hampson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/8/23

7 AGE	Years	Months	Days	If LESS than 1 day, 5 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Frank Isaiah Harrid.

11 BIRTHPLACE OF FATHER (city or town) Wash DC (State or country)

12 MAIDEN NAME OF MOTHER Bertha Morris.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address)

15 Filed JUN 8 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-8- 1923

17 I HEREBY CERTIFY, That I attended deceased from 6-8, 1923, to 6-8, 1923, that I last saw h[illegible] alive on 6-8, 1923, and that death occurred, on the date stated above, at 1:40 a.m.

The CAUSE OF DEATH* was as follows:

prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Susanne R Parsons M. D.

6-8. 1923 (Address) 1702 Westwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

20 UNDERTAKER — ADDRESS

Commissioner Health JUN 8 1923

N.B.—Answers to questions should be carefully supplied. AGE should be stated in every case. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76542

CERTIFICATE OF DEATH.

31 D76542

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 ST. Municipal Tuberculosis Hospital WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marian Rinehart

(a) RESIDENCE NO. 212 S. Bruce st. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Charles Rinehart

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. W. Bell

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Heffernan

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Maryland

14 Informant Hospital Records

(Address) M.T.H.

15 Filed JUN 8 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30, 1922, to June 5, 1923, that I last saw her alive on June 5, 1923, and that death occurred, on the date stated above, at 10.25 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Francis L. Dalaglacca M. D.

6-6-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	June 9 1923
20 UNDERTAKER	ADDRESS
John M. Weber	803 Bank St

B.—WHEN BLANKS are to be filled out, information should be carefully supplied. AGE, PLACE OF DEATH and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Hannoch

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76543

D76543 52

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1170 Washington Blvd. ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha A Jannoch

(a) RESIDENCE. No. 1170 Washington Blvd. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Chas Perisborn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER B Perisborn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) German

14 Informant Mrs Martha Jannoch
(Address) 1170 Washington Blvd.

15 Filed JUN 8 - 1923 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1st 1922, to June 6, 1923, that I last saw her alive on June 6, 1923, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Chronic arthritis deformans

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Robert P. Harrison, M. D.

June 7. 1923 (Address) 831 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 6/10/1923

20 UNDERTAKER Geo Leimbach & Son — ADDRESS 847 Paca St

mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D76544 | CERTIFICATE OF DEATH. | 46 | D76544

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary J. Talbott

(a) RESIDENCE NO. Marlborough 410 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dr. Thos. J. Talbott

6 DATE OF BIRTH (month, day, and year): June 26" 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Thomas H. Bradford

11 BIRTHPLACE OF FATHER (city or town) (State or country): North of Ireland

12 MAIDEN NAME OF MOTHER: Mary A. McAdams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant (Address): R. J. Bradford 3732 Greenmount Ave.

15 Filed JUN 8 1923 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 17, 1923, to June 8, 1923, that I last saw him alive on June 7, 1923, and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Vulva.
cachexia.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of April 27, 1923

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward A. Kalaowski, M. D.

(Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: June 11" 1923

20 UNDERTAKER: Joseph B. Cook

ADDRESS: 1003 W. Balto St.

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

JUN 8 1923

Spec.—1-10-21—M&T—1500 Bks.

D76545

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D76545

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Rear of Stonington Ave Howard Park ST. 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis W. Lawrence

(a) RESIDENCE NO. Howard Park ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vina Lawrence

6 DATE OF BIRTH (month, day, and year) Nov. 26th 1852

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. H. Lawrence

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rebecca Litchfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. John Horan

(Address) Howard Park, Md.

15 Filed JUN 8 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6th P 1923

17 I HEREBY CERTIFY, That I attended deceased from May 29th, 1923, to June 8th, 1923, that I last saw him alive on June 6th, 1923, and that death occurred, on the date stated above, at P.M. 9 m.

The CAUSE OF DEATH* was as follows: Carcinoma of Liver

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

6/18, 1923 (Signed) W. Linthicum, M. D.

(Address) Savage Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arrangt. McE. Funl Co	June 10, 1923
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Calvert St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76546

CERTIFICATE OF DEATH.

24 182 D76546

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. off Foot of Haubert St. ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph J. Appel.

(a) RESIDENCE NO. 1112 Hull St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 7 mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) November 6th. 1887.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	7	------	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Potter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Paul Appel.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna Holthaus.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Anna Appel. (mother)
(Address) 1112 Hull St.

15 Filed JUN 8 - 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6th. 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accidental Drowning.
Collision between steamer and scow.
(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner)

June, 8th. 1923 (Address) 10 7 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 6/9 1923

20 UNDERTAKER J. F. McCully

ADDRESS 1306 E. [illegible]

mation should be carefully supplied. Any that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.P.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76547

D76547

CERTIFICATE OF DEATH. 101-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 217 S Collington ave St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maryanna Kucharek

(a) Residence No. 217 S Collington ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	white	

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Joseph Kucharek

6-DATE OF BIRTH (month, day and year) Jan 25 1885

7-AGE. 38 yrs. 4 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Poland

PARENTS.

10-NAME OF FATHER. Adam Jaswinski

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER. unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14- (Informant) Joseph Kucharek

(Address) 217 S Collington ave

15- Filed JUN 6 1923 Robert F. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 6/23

17- I HEREBY CERTIFY, That I attended deceased from June 1 1923 to June 6 1923

that I last saw h.s.c. alive on June 6 1923

and that death occurred, on the date stated above, at 9400 o.m.

The CAUSE OF DEATH* was as follows:-

Lobar Pneumonia

(Double — bottom)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 2500 E. Eastern Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	June 9 1923
20-UNDERTAKER.	ADDRESS
Lohmann Weber	1803 Bank st

Exact statement of OCCUPATION should be carefully supplied. All entries should be made in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76548 ✓D76548

CERTIFICATE OF DEATH.

44

REGISTERED NO.

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No. ✓ 25 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Louise Kiessling

(a) RESIDENCE NO. 27 Cread St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. not known mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Kiessling

6 DATE OF BIRTH (month, day, and year) Jan 7 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Wm Kiessling (Address) 27 Cread St Curtis Bay

15 Filed ..... Robert P. Harrison; Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1923

17 I HEREBY CERTIFY, That I attended deceased from June 7 1923, to June 7 1923,

that I last saw her alive on June 7 1923

and that death occurred, on the date stated above, at 10 35 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Gall bladder & metas-
tases to liver

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? Yes Date of June 6. 1923

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation

(Signed) Ruth C. Reed, M. D.

, 19 (Address) Church Home & Infy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clark Station Kiessling Private RA. Co. DATE OF BURIAL June 10 1923

20 UNDERTAKER John M. Weber ADDRESS 1803 Bank

JUN 9 1923

N. B.—WRITE PLAINLY, with ink. All items should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

163832. D76549

HEALTH DEPARTMENT—CITY OF BALTIMORE D76549

CERTIFICATE OF DEATH.

X 16-002

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. " " " ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Ross.

(a) RESIDENCE NO. Owings Mills, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) March 15, 1923.

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
—	2	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Ross.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sylvia Turnbaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Robert P. Hutchcroft.

Filed JUN 9 1923 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1923

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1923. to June 7, 1923.

that I last saw her alive on June 7 1923.

and that death occurred, on the date stated above, at 9¼ P. m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) 0 yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Character of stools.

(Signed) William H. F. Warcher, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: June 9 1923

20 UNDERTAKER: William Cook.

ADDRESS: 502 E North.

GE should be carefully supplied. Exact statement of
hat it may be properly classified.
ns on back of certificates.
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Bacillary –
Broncho

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76550

CERTIFICATE OF DEATH.

49 D76550

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Union Memorial Hosp. 4th

CITY OF BALTIMORE: (NO. 1415 Linden ST., 12 WARD)

2-FULL NAME Sanford Kenny

(a) RESIDENCE NO. 215 West 23rd ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 18, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Michael Kenny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sallie Cassidy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Wallace C. Kenny (Address) 215 W. 23rd St

15 Filed JUN 9 1923, 19 ..... Registrar Robert P. Harrison; Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1923

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1923, to June 8, 1923, that I last saw him alive on June 8, 1923, and that death occurred, on the date stated above, at 1225 P.m.

The CAUSE OF DEATH* was as follows:

Sarcoma right Kidney

(duration) 2 (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of April 23, 1923

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) B Heuberger M. D.

, 19 (Address) U M H. Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross - Harford Rd - DATE OF BURIAL 6/11/1923

ADDRESS

20 UNDERTAKER Hm. Cook - 702 E. Hurth ave.

N.B.—WRITE PLAINLY. AGE should be carefully supplied. Exact statement of mation should be properly classified. so that it may be CAUSE OF DEATH in plain terms, TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76551

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76551

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 417 S. 13th St. (or) 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida J. Leaverton

(a) RESIDENCE NO. 417 S. 13th St., Highlandtown WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J. H. Leaverton

6 DATE OF BIRTH (month, day, and year): Feb 11 1864

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
59	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Talbot Co Maryland

PARENTS

10 NAME OF FATHER: Wm Cummings

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't know

14 Informant: Mr Wm H. Leaverton

(Address) 417 S. 13 st Highlandtown Md

15 Filed JUN 9 1923, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6 1923

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1923, to June 5, 1923, that I last saw h[illegible] alive on June 5, 1923, and that death occurred, on the date stated above, at 6 10 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver, Contrib. Cancer.

(duration) — yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Intestinal Toxemia;

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of March 1923

Was there an autopsy? No. Gradle

What test confirmed diagnosis? Gradle, Diagnosis.

(Signed) [illegible] M. D.

6-6, 19.... (Address) 550 Cath Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	June 9 1923
20 UNDERTAKER	ADDRESS
John F. Denny	715 Light St

B.—WRITE [illegible] mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D76552

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76552

CERTIFICATE OF DEATH.

74-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3202 Eastern Ave St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME W. Thomas Caddell

(a) Residence No. 3202 Eastern ave St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline C. Caddell

6-DATE OF BIRTH (month, day and year) April 30-1868

7-AGE. 55 yrs. 1 mos. 7 ds.

If LESS than 1 day ....hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman.

(b) General nature of industry, business, or establishment in which employed (or employer) Produce

(c) Name of employer Stevens Bros.

9-BIRTHPLACE (city or town) (State or Country) Havre de Grace, Md.

PARENTS.

10-NAME OF FATHER, William Caddell

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Scotland

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Not known

11- (Informant) Caroline C. Caddell

(Address) 3202 Eastern Ave

13- Filed JUN 9 1923 192 Robert P. Harrison, Registrar.

Earle Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 7-1923

17- I HEREBY CERTIFY, That I attended deceased from May 11 1923 to June 7- 1923

that I last saw h— alive on June - 7 1923

and that death occurred, on the date stated above, at 10:05 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage —

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Heat. (Exhaustion)

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) Frank C Bruder M. D

, 19 (Address) 125 E Baltimore

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Trinity

DATE OF BURIAL, June 10 1923

ADDRESS 1739 E Eager St

20-UNDERTAKER. Zirkler & Zirkler

Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Entries should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. AGE should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76553

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002

D76553

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3343 Chestnut Ave ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Unnifred Joyce White

(a) RESIDENCE. No. 3343 Chestnut Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~infant~~

6 DATE OF BIRTH (month, day, and year): Feby 25 1923

7 AGE: Years —; Months 2; Days 14; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~~infant~~

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Ernest Rukte

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Agatha Winston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Ernest F White

(Address) 3343 Chestnut Ave

15 Filed JUN 9 1923, 19 Robert F. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1923

17 I HEREBY CERTIFY, That I attended deceased from March 25 1923 to June 8 1923

that I last saw him alive on June 7 1923

and that death occurred, on the date stated above, at 7:00 a.m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical symptoms

(Signed) C Fentyadin M. D.

6-8 1923 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: June 9 1923

20 UNDERTAKER: Franklin H Seitz — ADDRESS: 709 W 33d

Burial Permit Clerk

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Isaac Brown)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76554 D76554

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 737 Leadenhall St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Isaac Brown

(a) Residence No. 737 Leadenhall St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) [illegible] 1857

7-AGE, 66 yrs. mos. ds. If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Coal & Wood

(b) General nature of Industry, business, or establishment in which employed (or employer): Dealer

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Isaac Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Maria Comisky

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Frances Mason

(Address) 737 Leadenhall St

15- Filed ..... 192 .....

Robert P. Harrison
Registrar.

JUN 9 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 7

17- I HEREBY CERTIFY, That I attended deceased from May 20, 1923, to June 7, 1923, that I last saw h[illegible] alive on June 7, 1923, and that death occurred, on the date stated above, at 11.25 p.m.

The CAUSE OF DEATH* was as follows:

Paralysis Cerebral Hemorrhage

(Duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) C't Disease

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation & Autopsy

(Signed) C. T. Fooden M. D.

June 8, 1923 (Address) 712 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt. Auburn — DATE OF BURIAL, June 9, 1923

20-UNDERTAKER, John H. Fooden — ADDRESS 142 Ostend St

should be carefully supplied. AGE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Inquiries on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76555

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76555

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2201 Eutaw Place St., 13 49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Isaac Stewart George

(a) Residence No. 2201 Eutaw Place St., 13 Ward, Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 7 mos. 0 ds. How long in U. S., if of foreign birth? 56 yrs. 7 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Katharine Baker George

6-DATE OF BIRTH (month, day and year) Nov-7-1866

7-AGE. 56 yrs. 7 mos. 0 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Real-Estate

(b) General nature of industry, business, or establishment in which employed (or employer)..... Real-Estate

(c) Name of employer..... Self

9-BIRTHPLACE (city or town)..... Baltimore

(State or Country)..... Maryland

PARENTS.

10-NAME OF FATHER. Jas. Brown George

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Fannie Cochran

13-BIRTHPLACE OF MOTHER (city or town). Baltimore (State or Country). Maryland

14-(Informant) Mrs Katharine B. George wife

(Address)..... 2201 Eutaw Place City

15-Filed JUN 9 1923 Robert P. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 7th 1923

17-I HEREBY CERTIFY, That I attended deceased from Sept. 6th 1921 to June 6th 1923 that I last saw h live on June 6th 1923 and that death occurred, on the date stated above, at 12.20 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of the larynx. Tracheotomy, done performed in Feb 1922. The breathing through tube 16 months (Duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

.....(Duration) one yrs. 9 mos.

18-Where was disease contracted if not at place of death? at place of death

Did an operation precede death? yes. Date of Feb 1922

Was there an autopsy? No.

What test confirmed diagnosis? Clinical History

(Signed) Louis K. Merrick M. D.

, 19 (Address) 824 Park Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Green Mount Cemetery. DATE OF BURIAL. June 9 1923.

20-UNDERTAKER. STEWART & HOWEN COMPANY ADDRESS 108 W. NORTH AVE. Baltimore

should be carefully supplied. Exact statement of occupation is necessary. Cause of death must be properly classified. Exact statement of cause must be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76556

CERTIFICATE OF DEATH.

46 D76556

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1912 Orleans ST., 6 WARD)

2-FULL NAME Annie E. Taylor

(a) RESIDENCE No 1912 Orleans ST., ... WARD ...
(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of -(or) WIFE of Albert E. Taylor

6 DATE OF BIRTH (month, day, and year) Dec 25 63

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Clifford Cissel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Albert E. Taylor 1912 Orleans

15 Filed JUN 9 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/7th 1923

17 I HEREBY CERTIFY, That I attended deceased from June ..., 19 23, to June 7th, 19 23, that I last saw h[im] alive on June 6th, 19 23, and that death occurred, on the date stated above, at 4 50 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus

(duration) 1 yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) Michael A Blasco, M. D.

, 19 (Address) 2360 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine	6/9 1923
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

A. B. C. Write plainly. All information should be carefully supplied. Exact statements of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of CAUSE OF DEATH in plain terms, so that it may be properly classified. ATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76557

CERTIFICATE OF DEATH.

118-00 D76557

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Moersberger

(a) RESIDENCE NO. 2834 Oliver ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 2 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of late Paul Moersberger

6 DATE OF BIRTH (month, day, and year) March 18 48

7 AGE: Years 75 Months 2 Days 28 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Frederick Ditzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Geo. F. Moersberger 400 E 28th St

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

JUN 9 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1923

17 I HEREBY CERTIFY, That I attended deceased from May 24 1923, to June 8 1923, that I last saw h[illegible] alive on June 8 1923 and that death occurred, on the date stated above, at 3:40 A m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Thrombophlebitis, Cerebral Hernia, Diabetes, acute nephritis, acute pneumonia (duration) 2 days ? - Patch - 4 days

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Exploratory Date of 5-27-23

Was there an autopsy? Yes

What test confirmed diagnosis? Bl Culture.

(Signed) Walter Sydney Lamar, M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem. DATE OF BURIAL 6/11 1923

20 UNDERTAKER Philip Hennig ADDRESS 2016 Orleans

N. B.—WRITE... mation should be carefully supplied. AGE should be ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement ... TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76558 CERTIFICATE OF DEATH. 100-001 D76558

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1416 Woodall ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Corinne Helen Hepping.

(a) RESIDENCE NO. 1416 Woodall ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 10 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 1, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Heppding

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Ethel McElwee.

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Ethel Heppding
(Address) 1416 Woodall St.

15 Filed . 19 Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1923

17 I HEREBY CERTIFY, That I attended deceased from May 25. 1923. to June 8. 1923.

that I last saw h alive on June 8. 1923.

and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. Fa Stevens M. D.

6/8. 1923 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL 6/11 1923

20 UNDERTAKER Philip Henry ADDRESS 2016 Orleans

N. B.—Information should be carefully supplied. AGE should be given in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gunnary

D76559

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76559

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1100 W Lanvale St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wesley Smith

(Residence in Baltimore: No. 1100 Whatcoat St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	colored	

6-DATE OF BIRTH, about 1[illegible]
(Month) (Day) (Year)

7-AGE. 34 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). N. C.

PARENTS.

10-NAME OF FATHER. Louis Smith

11-BIRTHPLACE OF FATHER. (State or Country). N. C.

12-MAIDEN NAME OF MOTHER. Louis Boyd

13-BIRTHPLACE OF MOTHER. (State or Country). N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Estella Smith

(Address) 1100 Whatcoat St.

15-

Filed ..... 192.. Registrar.

Robert P. Harrison;
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 7 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

192.. (Address)

*State the Disease causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Pub. Cemetery DATE OF BURIAL. June 11 1923

20-UNDERTAKER. Charles A. Willis & Trustman ADDRESS 1313

N. B.—Every item of information should be given, so that it may be properly classified. Each statement should be full and clear, and state CAUSE OF DEATH in plain terms

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76560

CERTIFICATE OF DEATH.

10 ✓ D76560

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 14 WARD)

2-FULL NAME Bernice Taylor

(a) RESIDENCE No. 1514 W Franklin ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 17, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer —

9 BIRTHPLACE (city or town) Balt md
(State or country)

PARENTS

10 NAME OF FATHER Matthew Taylor

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Julia Hornsby

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Mathew Taylor
(Address) 1514 W Franklin St

15 Filed JUN 9 1923 192 Robert P. Harrison; Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 7 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Suffocation Probably due to Edematous Diphtheria

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) —
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Gorsuch, M. D.
(Coroner.)
6-8-23, 1923 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery DATE OF BURIAL 6-10 1923

20 UNDERTAKER James H. Lewis ADDRESS 213

it may be properly classified. Enter name of ... mation should be given. Do not use abbreviations. ... CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back of certificate.

Spec. 1-10-21 MAT 1500 lbks.

D76561

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D76561

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William B. Kyler, Sr.

(a) RESIDENCE NO. 633 Pitcher Street ST., WARD.....

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Nettie F. Kyler

6 DATE OF BIRTH (month, day, and year) May 14, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	56	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O. R. R.

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md. Maryland.

PARENTS

10 NAME OF FATHER John T. Kyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert County, Md

12 MAIDEN NAME OF MOTHER Sarah E. Isaac

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert County, Md

14 Informant Nettie F. Kyler (Address) 633 Pitcher Street

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1923

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1923, to June 8, 1923, that I last saw h[illegible] alive on June 8, 1923, and that death occurred, on the date stated above, at 6 30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

..... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs &c.

(Signed) Wm. J. Fulton, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL June 11 1923

20 UNDERTAKER Jno. M. Johnson

ADDRESS 209 Druid Hill Ave

Robert F. Garrison,
Burial Permit Clerk.

...mation should be carefully supplied. ...
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement ...
TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76562

CERTIFICATE OF DEATH.

D76562

REGISTERED NO. 4/100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Smith

(a) RESIDENCE NO. ~~66 Mt~~ 107 E. Pleasant St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE. Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Wm. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Caroline Hammer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto., Md

14 Informant Municipal Hospital Records. (Address)

15 Filed JUN 9 1923, 19 Robert P. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7, 19 23

17 I HEREBY CERTIFY, That I attended deceased from May 24, 19 23, to June 7, 19 23, that I last saw her alive on June 6, 19 23, and that death occurred, on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Senility

Arteriosclerosis

Hypertension

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (Terminal) (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McPowell, M. D.

6-8-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL June 9 1923

20 UNDERTAKER Jno. M. Johnson

ADDRESS 1309 Druid Hill

Information should be carefully supplied. Any certificate may be properly classified. Exact statements should be made in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements on back of certificates. See instructions on back of certificates. See instructions on back of certificates. See instructions

Spec– 12-23-21 – E.B.R.S.–400 Bks.

D76563

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76563

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 96 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Chinn

(a) Residence No. Bay View Asylum St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1869

7-AGE. 74 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town). ? (State or Country).

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town). ? (State or Country).

14- (Informant) Municipal Hospital Records

(Address)

15- Robert P. Harrison, Registrar.

JUN 9 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 6, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 7 1920 to June 6 1923.

that I last saw her alive on June 5 1923.

and that death occurred, on the date stated above, at 4:00 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Terminal) (Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. M. Powell, M. D.

6-9- 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. ....., 19....

20-UNDERTAKER. ADDRESS

JUN 9 - 1923

0457

Should be carefully answered. Exact statement of cause of death required. Terms like "Heart Failure," "Exhaustion," "Old Age," "Paralysis," "Convulsions," etc., should be explained by stating the disease causing the condition. Cause of death must be certified to in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76564

D76564

CERTIFICATE OF DEATH.

162

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., 11 WARD)

2-FULL NAME Baby Thomas.

(a) RESIDENCE NO. 944 N. Howard ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 10, 1923

7 AGE — Years — Months — Days: 6 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Md.

10 NAME OF FATHER James Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant W. W. Gray

(Address) .....

15 Filed JUN 9 1923, 19 ..... Robert P. Harrison Registrar

Deputy Health Commissioner Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch. 10, 1923, to Mch 16, 1923.

that I last saw him alive on Mch 16, 1923 9.25 A.m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? yes.

What test confirmed diagnosis? —

(Signed) W. W. Gray, M. D.

19 ..... (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL —

DATE OF BURIAL

19 1923

20 UNDERTAKER —

ADDRESS —

JUN 8

Johns Hopkins Hospital

Baltimore, Md.

Dept. of Health.

Mar. 1923

Johns Hopkins Hospital

Baltimore, Md.

Dept. of Health.

Mar. 1923

Mrs. Thomas

Mation should be carefully supplied. Any information may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D76565

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76565

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Johns Hopkins Hospital ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hazel

(a) RESIDENCE NO. 410 Register ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of)

6 DATE OF BIRTH (month, day, and year) 5/18/23.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or — min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Harris

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Hazel

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant W.W. Gray (Address) Johns Hopkins Hospital

15 Filed ..... 19 ..... Registrar

JUN 9 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/19 1923

17 I HEREBY CERTIFY, That I attended deceased from 5/18/ , 1923 , to 5/19 , 1923 .

that I last saw her alive on 5/19 , 1923 ,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) W.W. Gray, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Johns Hopkins Hospital.	19
ADDRESS	1923

20 UNDERTAKER .....

N. B. All items should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76566

CERTIFICATE OF DEATH.

162nd

D76566

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bell

(a) RESIDENCE NO. 211 N. Spring ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 3, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	-	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Rossiz Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mildred Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash. D.C.

14 Informant W.W. Gray, Johns Hopkins Hosp

(Address)

15 Filed JUN 9 1923, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1923

17

I HEREBY CERTIFY, That I attended deceased from 10th A.M. June 3, 1923, to 9th P.M. June 3, 1923,

that I last saw him alive on June 3, 1923,

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

Congenital

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W.W. Gray, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 19
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL JUN - 1923

N. B.—Information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D76567 HEALTH DEPARTMENT—CITY OF BALTIMORE D76567

CERTIFICATE OF DEATH. X 74-001

1-PLACE OF DEATH Christs Institution Hospital

CITY OF BALTIMORE: (No. 704 Ensor St ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosha Hutchinson

(a) RESIDENCE NO. 1102-R-St N.W. Wash D.C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds. 10

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David Hutchinson

6 DATE OF BIRTH (month, day, and year): Unknown 1874

7 AGE: 49 (Years / Months / Days; If LESS than 1 day, hrs or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Samuel Tucker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Sarah Brad

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Hunter Trooper (Address) 1802 E Clinton st

15 Filed 1923 . 19 Robert T. Harrison, Registrar

Burial Permit Clerk.

N 9

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8- 1923

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1923, to June 8-, 1923, that I last saw he alive on June 8-, 1923, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

apoplexy

Asthma & Dropsy

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Asthma Dropsy & Paralysis (duration) yrs. 67 mos. 11 ds.

18 Where was disease contracted if not at place of death? Wash. D.C

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D.W. Kennard, M. D.

6-8, 1923 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D.C. DATE OF BURIAL: June 9 1923

20 UNDERTAKER: John W Henderson ADDRESS 1502 Monument St.

mation should be carefully supplied. Exact statement CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D76568 HEALTH DEPARTMENT—CITY OF BALTIMORE D76568

CERTIFICATE OF DEATH. Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Rueben Brown 2 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME 1104 E. Lexington 1

(Residence in Baltimore: No. 1104 E. Lexington St.; yrs. 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	black	[illegible]

6-DATE OF BIRTH. ..... (Month) 1871 (Day) 1..... (Year)

7-AGE. 52 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Balto. Co. Md.

PARENTS.

10-NAME OF FATHER. George Brown

11-BIRTHPLACE OF FATHER. (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Fannie Adams

13-BIRTHPLACE OF MOTHER. (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julia Brown (wife)

(Address) 1104 E. Lexington

15- Filed JUN 9 1923 192 Registrar. Robert P. Harrison; Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. ..... June (Month) 5/23 (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Syphilis reported

(Duration) ....yrs. several mos. ds.

(Signed) J. S. H. Mackenzie M. D. (Coroner.)

6/8/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Laurel Cemetery DATE OF BURIAL. June 9 1923

20-UNDERTAKER. Mrs. R. C. Elliott ADDRESS Undertaker

N. B.—Every item of information should be given, so that it may be properly classified. State CAUSE OF DEATH in plain terms, so that it may be understood. The date of burial is very important. See instructions on back of certificate.

Spec.—I-10-21—MAT—1500 Blks.

D76569

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76569

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 St Joseph ST., 8 WARD)

2-FULL NAME Lovenia Bland.

(a) RESIDENCE No. 1618 St. Joseph ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 9, 1909

7 AGE: Years 14 Months ... Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER George Bland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER Hallie Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Hallie Briner

(Address) 1618 St Joseph st-

15 Filed JUN 9 1923. 19 ... Robert T. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-7-1923

17 I HEREBY CERTIFY, That I attended deceased from 6-4-, 1923, to 6-7-, 1923, that I last saw h[illegible] alive on 6-7-, 1923, and that death occurred, on the date stated above, at 7, 15 P.M.

The CAUSE OF DEATH* was as follows:

Cerebro-spinal meningitis

(duration) ... yrs. ... mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

6-8-1923 (Address) 611-N-Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: 1923

20 UNDERTAKER: Mrs. Robt. Elliott

ADDRESS: Baltimore.

INFORMATION should be carefully supplied. Each item may be properly classified. Exact wording should be used in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact wording should be used in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Epidemic

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D76570

CERTIFICATE OF DEATH. 11-001

D76570

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 Division ST., 14 WARD)

2-FULL NAME Mrs. Louisa Miner

(a) RESIDENCE NO. 1502 division ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Leph Miner

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housekeeping

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pocomoke City, Md

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown.

14 Informant (Address): 1502 E. Oregon Ave

15 Filed JUN 9 1923, 19 Robert F. Morrison; Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-7 1923

17 I HEREBY CERTIFY, That I attended deceased from 5-31- , 1923, to 6-7- , 1923.

that I last saw h. alive on " , 19

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary): Arterio-Sclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Cardozo, M. D.

6-7- 1923 (Address) 1524 Druid Hill Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: June 10 1923

20 UNDERTAKER: Mrs. R. A. Elliott — ADDRESS: Baltimore

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated in years, months and days. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. Will Call for certificate c 91 a, mv

D76571

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D76571

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2731 Rayner Av ST., 16 WARD)

2-FULL NAME William D. Dulaney

(a) RESIDENCE No. 2731 Rayner Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Mc. Dulaney

6 DATE OF BIRTH (month, day, and year): May 28-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cane Maker

(b) General nature of industry, business, or establishment in which employed (or employer): Any Manufacturing

(c) Name of employer: Company

9 BIRTHPLACE (city or town) (State or country): Washington D. C.

PARENTS

10 NAME OF FATHER: Wm. Dulaney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Anna Peace

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Marcellus Dulaney 2731 Rayner Av

15 Filed JUN 9 1923, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1923. to June 7, 1923.

that I last saw him alive on June 7, 1923.

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary) myocarditis & Oedema of Lungs

(duration) yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chyo Examination

(Signed) John A. Nolan, M. D.

6/8, 1923 (Address) 12 19 Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westgate Cemetery — DATE OF BURIAL: June 9 1923

20 UNDERTAKER: J. B. Hepfinger — ADDRESS: 2336 Eutaw Av

Information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76572 D76572

CERTIFICATE OF DEATH.

160

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2654 Dulaney ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas. L. Rousser

(Residence in Baltimore: No. 2654 Dulaney St.; yrs., 3 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Feb 28 (Month) (Day), 1923 (Year)

7-AGE, ...yrs. 3 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Fernand Rousser

11-BIRTHPLACE OF FATHER (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER Lula Stemmler

13-BIRTHPLACE OF MOTHER (State or Country) Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lula Rousser

(Address) 2654 Dulaney Pl.

15- Robert F. Harrison;

Filed ..... 191..... Registrar.

JUN 9 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 8 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 2 1923, to June 8 1923, that I saw him alive on June 8 1923, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) ....yrs. 1 mos. 10 ds.

Heat Prostration

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. 1 ds.

(Signed) J. T. Owens M. D.

June 9, 1923 (Address) 804 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cemetery DATE OF BURIAL, JUNE 9 1923

20-UNDERTAKER F. B. Pierpont ADDRESS 1216 Fremont Ave

N.B.—Every item of information should be properly answered. Especially CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D76573

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76573

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2821 St Paul ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Elizabeth Steinbach

(a) RESIDENCE NO. 2821 St Paul ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, ~~(write the word)~~ Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Steinbach

6 DATE OF BIRTH (month, day, and year) Aug. 14-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Joseph Stephan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Minnie Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John F. Steinbach 2821 St Paul St

15 Filed JUN 9 1923, 19 Robert P. Harrison, Registrar

Harold Perrit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 21, 19 to June 8, 1923, that I last saw he alive on June 8, 1923, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Arterio-Sclerosis

(duration) 6y yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John S. Bishop, M. D.

. 19 (Address) 930 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL June 11 19 23

20 UNDERTAKER W. Edward Hoffe

ADDRESS 1234 Edmondson Ave

Spec.—1-10-21—M&T—1500 Blks. ... mation should be carefully supplied. Exact state ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

D76574

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76574

CERTIFICATE OF DEATH.

179-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2903 - Cedar Ave St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Wall

(Residence in Baltimore: No. 2903 Cedar Ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word)
M	W	Single

6-DATE OF BIRTH, April 11 (Month) (Day) 92 (Year)

7-AGE. 6 yrs. 7 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. W. S. Wall

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Lola Chaney

13-BIRTHPLACE OF MOTHER, (State or Country). Ind

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Garland S. Wall

(Address) 2903 Cedar Ave

15- Filed June 9 1923 Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 8 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns, Arm
Exhaustion
Fire with Alcohol

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.
(Coroner)

June 9 1923 (Address) 362 N. Carey

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL, June 9 1923

St Marys Hospital

20-UNDERTAKER'S NAME AND ADDRESS. CHENOWETH & SON, 3617 CHESTNUT AVE.

N. B.—Every item of information should be given, so that it may be properly classified. Exact wording should be used in stating CAUSE OF DEATH in plain terms

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76575

CERTIFICATE OF DEATH.

D76575

90

REGISTERED NO.

1-PLACE OF DEATH Church Home & Hospital ST., 18 WARD)

CITY OF BALTIMORE: (NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Leah Keiser

(a) RESIDENCE NO. Church Home & Hospital ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 8 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Kathryn Elliott 1st Nat'l Bk. Schroeder & Mullen

15 Filed JUN 9 1923, 19 Robert F. Hartbom Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1923

17

I HEREBY CERTIFY, That I attended deceased from June 3, 1923, to June 8, 1923,

that I last saw h... alive on June 8, 1923,

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Myocarditis: Senility Cardio-nephritis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A Lanman, M. D.

19 (Address) South Balto Gen/Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL June 8 1923

ADDRESS (53d Holins

20 UNDERTAKER George J Smith

Information should be carefully supplied. Age should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. This information is very important.

Spec.—1-10-21—M&T—1500 Bks. 76576

HEALTH DEPARTMENT—CITY OF BALTIMORE

64054 D76576 X 49 D76576

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harvey Powell

(a) RESIDENCE NO. 105 Maryland St. Macon Ga. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banker

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ga (State or country)

PARENTS

10 NAME OF FATHER Hugh J. Powell

11 BIRTHPLACE OF FATHER (city or town) Ga (State or country)

12 MAIDEN NAME OF MOTHER Martha Cottrill

13 BIRTHPLACE OF MOTHER (city or town) Ga (State or country)

14 Informant JOHNS HOPKINS HOSPITAL (Address)

JUN 10 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9. 1923

17 I HEREBY CERTIFY, That I attended deceased from May 30 1923 to June 9. 1923.

that I last saw him alive on June 9. 1923.

and that death occurred, on the date stated above, at 1 5 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder

(duration) yrs. 7 mos de.

CONTRIBUTORY (Secondary) Shock, post-Operative

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of June 5. 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. W. Lewis M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Macon Ga. DATE OF BURIAL June 12 1923

20 UNDERTAKER John O Mitch[illegible] ADDRESS 1201 W Fayette St

Exact statement of occupa-
may be properly classified.
back of certificate.

mation should be carefully supplied. AGE should
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

D76577 — 46 — D76577

REGISTERED No. C

D76577
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 431 N. Eden ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cora L. Watts

(Residence in Baltimore: No. 431 N. Eden st St.; Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	C	Widowed

6-DATE OF BIRTH, ... (Month) Dec (Day) 18, (Year) 1871

7-AGE, 52 yrs. 6 mos. 25 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wm Harris

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Mary E Jones

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sulpurnia Young

(Address) 431 N. Eden st

15- JUN 10 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 7 (Day), 1923 (Year).

17- I HEREBY CERTIFY, That I attended deceased from April 1923, to June 7 1923, that I saw her alive on June 5 1923, and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma uteri

(Duration) ....yrs. 2 mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) R J Young M. D.

6/7, 1923 (Address) 1429 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery | DATE OF BURIAL. June 10, 1923

20-UNDERTAKER Jos. T. Rochester | ADDRESS 1443 Jefferson St

N.B.—Every item must be filled in plain terms, so that it may be plainly understood. CAUSE OF DEATH in plain terms, so that it may be plainly understood. CAUSE OF DEATH must be plainly stated. Every item important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

(See Letter attached) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76578

CERTIFICATE OF DEATH.

X129 D76578

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1029 Myrtle ave ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene S. Plummer

(Residence in Baltimore: No. New York City St.; yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Legal Separation Divorced

6-DATE OF BIRTH, Not stated (Month) (Day), 1878 (Year)

7-AGE, about 45 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), N.C.

PARENTS.

10-NAME OF FATHER, John S. Plummer

11-BIRTHPLACE OF FATHER (State or Country), N.C.

12-MAIDEN NAME OF MOTHER Maria Owens

13-BIRTHPLACE OF MOTHER (State or Country), N.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Beulah G. Fuller (Sister)

(Address) 1029 Myrtle Ave

15-

JUN 10 1923 ROBERT R. KRAUTER,

Filed....., 191.... Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 7th (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 8th 1923, to June 7th 1923, that I saw h— alive on June 6th 1923, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Glomerulo nephritis

(Duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) None Known

(Duration) — yrs. — mos. — ds.

(Signed) Chas. Weller M. D.

....., 191... (Address) 232 W. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death — yrs. — mos. 30 ds. In the State — yrs. — mos. 30 ds.

Where was disease contracted, if not at place of death? N.Y. city

Former or usual residence N.Y. city

19-PLACE OF BURIAL OR REMOVAL, Warrenton, North Carolina

DATE OF BURIAL. June 10. 1923

20-UNDERTAKER Jno. M. Johnson

ADDRESS 1309 Druid Hill Ave

N. B.—EVERY ANSWER must be written in plain terms, so that it may be properly understood. CAUSE OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificate.

REG. No 715

DR CHARLES J. KELLER
222 W. MONUMENT ST
PHONE. VERNON 4829

OFFICE HOURS
8 TO 9 A M.
3 TO 4 P M.
7 TO 7 45 P M.

DATE June ~~28~~ 23

ADDRESS D. 76578

PATIENT'S NAME

R Eugene S. Plummer, who died June 7-23 at 1029 Myrtle ave. should have been reported as "legal separation" instead of divorced.

B. A. KRIEGER DRUG CO
HOWARD & MONUMENT STS
BALTIMORE, MD

FULL NAME Chas J Keller M. D

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

D76579 ✓

REGISTERED NO. D76579

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1603 E Monument ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert Ross

(a) RESIDENCE. No. 1603 E monument ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. + mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12-1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER James Strawn

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Lillian Ross

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Lillian Ross
(Address) 1603 E monument St

15 JUN 10 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1923

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1923, to June 9, 1923, that I last saw h— alive on June 8, 1923, and that death occurred, on the date stated above, at 6 40 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Whooping cough

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Edward Fisher, M. D.

6-9. 1923 Address 1612 E monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem.	11 19
20 UNDERTAKER	ADDRESS

mation should be carefully, ... so that it may be properly ... CAUSE OF DEATH in plain terms, ... TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76580

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76580

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Scott

(a) Residence No. 804 W 37th St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mrs Chas Scott

6-DATE OF BIRTH (month, day and year) Nov 13 1854

7-AGE. 68 yrs. 6 mos. 28 ds. If LESS than 1 day ....hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Joseph Scott

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER. Mary Suah

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

11- (Informant) Mrs L Scott

(Address) 604 W 37th. St

15- JUN 10 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 9 1923

17- I HEREBY CERTIFY, That I attended deceased from June 5 1923 to June 9 1923 that I last saw h. m alive on June 9 1923 and that death occurred, on the date stated above, at 12:30 a m

The CAUSE OF DEATH* was as follows:

Right Inguinal Strangulated Hernia × Diabetes Mellitus

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Hermitage

Did an operation precede death? Yes Date of June 5, 1923

Was there an autopsy? No

What test confirmed diagnosis? Benedicts Sugar test

(Signed) D. J. Pessagno M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. H Peters

DATE OF BURIAL, June 12 1923

20-UNDERTAKER. Robt L Turner

ADDRESS 1642 Broadway.

I. EXACT STATEMENTS should be carefully supplied. Entries may be properly classified. in plain terms, so that it may be instructions on back of certificates.

FILMED

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76581

CERTIFICATE OF DEATH.

129 D76581

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2833 Reese St ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Rebecca Williams.

(a) RESIDENCE NO. 2833 Reese St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm. T. Williams

6 DATE OF BIRTH (month, day, and year) Cengust 17th 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Canine Forge Co Md.

PARENTS

10 NAME OF FATHER Hebpew Platshek

11 BIRTHPLACE OF FATHER (City or town) Canine Forge Co (State or country) Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (City or town) Canine Forge Co (State or country) Md.

14 Informant Wm T. Fletcher (Address) 2833 Reese St.

15 Filed JUN 10 1923 ROBERT R. KRAUTER Remarks Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 11th, 1923, to June 8th, 1923, that I last saw her alive on June 8th, 1923, and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Anaemia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pernicious Anaemia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Jos. W. Hemfelt M. D.

6/9, 1923 (Address) 1016 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pimmit Gargle Co. Md.

DATE OF BURIAL June 11 1923

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1225 Ashland Ave

It may be properly classified. Exact statements
mation should be carefully supplied. Infor
CAUSE OF DEATH in plain terms, so that it may
on back of certificates.
TION is very important. See instructions on back

U.S.A. FEDERAL

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76582

D76582

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 54 Market Place ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathaniel Wilson

(a) RESIDENCE NO. 54 Market Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Wilson

6 DATE OF BIRTH (month, day, and year) Mar. 22 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fish Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER John F.W. McClennen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Ellen Warmsley

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Maryland

14 Informant Michael J. Cook
(Address) 424 S. Hanover St.

15 JUN 11 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 1, 1923 to June 8, 1923

that I last saw h alive on June 8, 1923

and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia Coma (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) J Wilson Thomas, M. D.

(Address) 1226 N. Caroline St.

June 7 23

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery. DATE OF BURIAL June 11 '23

20 UNDERTAKER Joseph B Cook ADDRESS 1003 N. Balto St

I. P. mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of

...y be properly classified. Exact statement of ...
...ck of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76583

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76583

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 943 Harford Ave St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Michael J. Sullivan

(a) Residence No... 943 Harford Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Ella J Sullivan

6-DATE OF BIRTH (month, day and year) Sept 27 1871

7-AGE, 57 yrs. 8 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)... was retired for years

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Maurice Sullivan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Ellen McGuire

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) wife Mrs Ella Sullivan

(Address) 943 E. Eager st

15- JUN 11 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 8 1923

17- I HEREBY CERTIFY, That I attended deceased from Feb 21 1923 to June 8 1923

that I last saw him alive on June 7 1923,

and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

a Tuberculosis Pulmonalis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) M C Cooke, M. D.

June 9, 1923 (Address) 111 S Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral Cemetery — DATE OF BURIAL, June 11 1923

20-UNDERTAKER, Elmer W Conkle — ADDRESS 1246 Eager

Should be carefully filled in, in plain terms, so that it may be properly classified. Exact statements as to cause of death required. See instructions on back of certificate.

Spec.—S-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76584 — CERTIFICATE OF DEATH. — 1607 — D76584

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homeward Hospital St.; 15 Ward) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm B Cook

(Residence in Baltimore: No. 2014 Longwood St.; 2 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Dec 1 - 1856, 1 (Month) (Day) (Year)

7-AGE, 67 yrs. 6 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Mill-wright
(b) General nature of industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Larkin S Cook

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Eliza Martin

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Smith

(Address) 404 Methuen St

15-

Filed JUN 11 1923 ROBERT B. KRANTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 10, 1923. (Month) 10 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 20 1923, to June 10 1923, that I saw him alive on June 10 1923, and that death occurred, on the date stated above, at 3 a.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H G Jones M. D.

, 191... (Address) 720 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos 21 ds. In the State 20 yrs. mos. ds.

Where was disease contracted, if not at place of death? —

Former or usual residence 2014 Longwood St

19-PLACE OF BURIAL OR REMOVAL. London Park — DATE OF BURIAL, June 13, 1923

20-UNDERTAKER George J Smith — ADDRESS Hollins St

N. B.—Every item of information should be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

164131. D76585

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D76585

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. " " " ST., 5 WARD)

CITY OF BALTIMORE: (NO.

2-FULL NAME Henry Rickes.

(a) RESIDENCE NO. 513 East St. - City. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Melinda Rickes (wife)

6 DATE OF BIRTH (month, day, and year): ?

7 AGE: Years 38 | Months ? | Days ? | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia,

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Records.

15 JUN 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1923. to June 7 1923.

that I last saw him alive on June 7, 1923.

and that death occurred, on the date stated above, at 5.55 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes -

What test confirmed diagnosis? autopsy

(Signed) C Cowles Andrus, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asb Cemetery

DATE OF BURIAL: June 11 1923

20 UNDERTAKER: Edward Brown

ADDRESS 1631 Orleans St

mation should be carefully supplied. that it may be properly classified. Exact
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

96 D76586

D76586

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 N. Fine st ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachael Cohen

(a) RESIDENCE NO. 103 N Fine st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 19 mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Cohen

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 71 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris Boymel

11 BIRTHPLACE OF FATHER (city or town) ... (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Leaf —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Philip Steinberg

(Address) 103 N Fine Street

15 Filed JUN 11 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1923

17 I HEREBY CERTIFY, That I attended deceased from May 12th, 1923. to June 9 1923.

that I last saw h[illegible] alive on June 9 1923.,

and that death occurred, on the date stated above, at 1225 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Indefinite (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation (duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Glassman M.D.

Jun 10 1923 (Address) 2687 Pratt Lewis Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rit Carmel — DATE OF BURIAL 6/11 1923

20 UNDERTAKER Jack Lewis 1439 E Baltimore — ADDRESS

Information should be carefully supplied. Entry may be properly classified. Any information should be carefully supplied. Entry may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Varga.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. ×57

D76587 Registered No. D76587

1-PLACE OF DEATH City of BALTIMORE: (No. Mercy Hospital St., 4 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Varga. Ward Queens Hotel NY

(a) Residence No. Queens Hotel Baltimore (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Varga

6-DATE OF BIRTH (month, day and year) June 21 1860

7-AGE 62 yrs. 11 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Baltimore Md.

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS:
10-NAME OF FATHER, Julius Bleyenberg
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany
12-MAIDEN NAME OF MOTHER, Jennie Baer
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-(Informant). Ena Blumberg
(Address) NY

15- JUN 11 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 10 1923

17- I HEREBY CERTIFY, That I attended deceased from June 8 1923 to June 10 1923
that I last saw h alive on June 10 1923
and that death occurred, on the date stated above, at 4 10 P. m.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus

(Duration) D yrs. mos. ds.

CONTRIBUTORY (Secondary) Acidosis, Asthenia
(Duration) yrs. mos. D ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms Signs

(Signed) N. J. Pierce M. D.
, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park DATE OF BURIAL. June 12 19 23

20-UNDERTAKER. J. Aberson & Co ADDRESS 1611 Madison

Should be carefully prepared so that it may be properly classified. Entries must be in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76588 CERTIFICATE OF DEATH. 146 D76588

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Bessie Cager

(a) RESIDENCE NO. 642 W. Redwood St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saundress 041

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Seeward Cager.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Bessie Bacon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Bessie Bacon

(Address) 642 W. Redwood St

15 JUN 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-7. 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 31 . 1923 . to June 7 . 1923 .

that I last saw her alive on June 7, . 1923 .

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Cholemia -

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? 642 W. Redwood St.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Typical Signs & Symptoms

(Signed) Wm. J. Fuller M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glenbelly Chapel

DATE OF BURIAL 6-11 1923

20 UNDERTAKER Daniel Easton

ADDRESS 916 Ca ...

mation should be carefully supplied. EACH ... that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

164149
D76589

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 D76589
REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 98 WARD)

2-FULL NAME John Bromwell.

(a) RESIDENCE No. 1904 Patterson Place ST., City WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
~~(or) WIFE of~~ HUSBAND of Lillian Bromwell (wife)

6 DATE OF BIRTH (month, day, and year) ? 1887.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	?	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ? 089
(b) General nature of industry, business, or establishment in which employed (or employer) ?
(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS
10 NAME OF FATHER John Bromwell.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Emma Clarke.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 JUN 11 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 4 .1923. to June 8 .1923.
that I last saw him alive on June 8 .1923.
and that death occurred, on the date stated above, at 10:5 A. m.

The CAUSE OF DEATH* was as follows:
Rheumatic Endocarditis
Myocardial Insufficiency.

(duration) yrs. mos da.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Stable Gray
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy.

(Signed) Chas. W. Cramming M. D.
(Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Oak Lawn Cemetery
DATE OF BURIAL 6/11 1923

20 UNDERTAKER George & Ruth
ADDRESS

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76590

CERTIFICATE OF DEATH.

REGISTERED NO. D76590

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME J. Henry Wenzel

(a) RESIDENCE NO. Possville Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna A. Wenzel

6 DATE OF BIRTH (month, day, and year) 8-6-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	10	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sheet metal worker
(b) General nature of industry, business, or establishment in which employed (or employer) 084
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas Wenzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Anna A. Wenzel (Address) Catonsville Md.

15 Filed JUN 11 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured Skull

(duration) yrs. 1 mos. hrs. ds.

CONTRIBUTORY (Secondary) Suicide Jumped from porch

(duration) yrs. mos. ds.

(Signed) W W Lewis M. D. (Coroner.)

6-11- 1923 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery DATE OF BURIAL June 12 1923

20 UNDERTAKER Fredk Lassahn & Sons ADDRESS Fulberton

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate. ATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76591

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D76591

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 N Bond St. 8 WARD)

2-FULL NAME William H Jones.

(a) RESIDENCE. NO. 1623 N Bond St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Bertha Jones.

6 DATE OF BIRTH (month, day, and year) Oct 19/1848.

7 AGE: Years 74 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer 30

(b) General nature of industry, business, or establishment in which employed (or employer): Shift Piano Mfg

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER William H. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Martha Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant Mrs. Bertha E. Jones. (Address) 1623 N. Bond St.

15 Filed JUN 11 1923 ROBERT R. KRANTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1923

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1923, to June 9, 1923 that I last saw him alive on June 9, 1923, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W Sandiman M. D.

, 19 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	June 12 1923

20 UNDERTAKER: George J. Ruth ADDRESS 1735 Harford Ave.

mation should be furnished; CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76592

CERTIFICATE OF DEATH

129 D76592

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. H. Sinclair

(a) RESIDENCE NO. 247 S. Highland Ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Wm Sinclair

6 DATE OF BIRTH (month, day, and year) 1879-Oct 3

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Sinclair

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Barker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Wm Sinclair

(Address) 247 S. Highland Ave

15 JUN 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/8 1923

17 I HEREBY CERTIFY, That I attended deceased from 6/6, 1923, to 6/8, 1923, that I last saw him alive on 6/8, 1923, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Edema

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab.

(Signed) Iron Jordon, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: June 11 1923

20 UNDERTAKER: A. Gander & Sons — ADDRESS: 1710 Eutaw St

mation should be carefully supplied. Each item should be properly classified, so that it may be
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76593

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D76593

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1124 China ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah King

(a) RESIDENCE NO. 1124 China ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of (?)

6 DATE OF BIRTH (month, day, and year) June 1st 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Robert Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Essex Co Va

12 MAIDEN NAME OF MOTHER Margett Payne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tom's Va

14 Informant Mary Carter
(Address) 1124 Chimes St

15 JUN 11 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1923

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1923, to June 8, 1923, that I last saw her alive on June 8, 1923, and that death occurred, on the date stated above, at 4.20 A. m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Lues

(duration) ? yrs. ? mos ? ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. H. Connell, M. D.

6/10, 1923 (Address) 140 Courtland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL June 11, 1923

20 UNDERTAKER Jno Robert A Elliott — ADDRESS 1725 Ashland Ave

mation should be carefully supplied. Let it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76594

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 38 D76594

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Farrow

(a) RESIDENCE No. 1124 Low St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Bailey Farrow

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Municipal Hospital Records. (Address)

15 JUN 11 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1923 to June 6, 1923, that I last saw him alive on June 5, 1923 and that death occurred, on the date stated above, at 2:00 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis

Syphilitic Aortitis

Aneurism of Innominate

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. M. Powell, M. D.

6-6-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL June 11 1923

20 UNDERTAKER Mrs R A Elliott

ADDRESS 1725 Ashland Ave

N. B. ... mation should be carefully supplied. Age ... that it may be properly classified. Exact statement of ... CAUSE OF DEATH in plain terms, so that ... TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76595

CERTIFICATE OF DEATH.

6 129

D76595 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 109 N Luzerne ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J Hurst

(a) Residence No. 109 N Luzerne ave Ward

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Femal

4-COLOR OR RACE. White

5-Single, Married, Widowed, or ~~Divorced~~ (Write the word.) Widowed

5a-If married, widowed, or divorced (HUSBAND of or) WIFE of Late Frank R. Hurst

6-DATE OF BIRTH (month, day and year) Jan 19-1848

7-AGE. 75 yrs. 4 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Not Known

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Emma Smith

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Baltimore Md

11- (Informant) Anna C Schoenhals

(Address) 109 N Luzerne ave

15- Filed JUN 11 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 7-23

17- I HEREBY CERTIFY, That I attended deceased from May 15 1923 to June 7 1923 that I last saw h[illegible] alive on 6/ 7 1923 and that death occurred, on the date stated above, at 830 P m. The CAUSE OF DEATH* was as follows:

Hardening of arteries

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bright's Disease (Duration) 2 yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C E Hunt Beach M D

(Address) 3901 Gorsuch Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem

DATE OF BURIAL. June 11 1923

20-UNDERTAKER. Wm C Grille

ADDRESS 2334 Jeffers st

In order to save space, so that it may be properly classified, write in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

12-002 12 D76596

D76596

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Alhambra Apt 12 ST. WARD)

2-FULL NAME Emanuel H. Fred

(a) RESIDENCE NO. Alhambra apt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Fannye Fred

6 DATE OF BIRTH (month, day, and year) May 22/1851

7 AGE	Years	Months	Days	tt LESS than 1 day, ...hrs. or ....min.
	72		18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clothing Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) 045
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Fred

tt BIRTHPLACE OF FATHER (city or town) (State or country) Germany

t2 MAIDEN NAME OF MOTHER Sobia Getz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fannye Fried (Address) Alhambra Apts

15 FILED JUN 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 2, 1923, to June 9, 1923, that I last saw h[illegible] alive on June 9, 1923, and that death occurred, on the date stated above, at 6.30 P.m.

The CAUSE OF DEATH* was as follows:

Uraemia (duration) 6 hours

CONTRIBUTORY (Secondary) Cirrhosis of Liver (duration) yrs. 3 mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harvard Kahn, M. D.

6/9 1923 (Address) 202 W Mt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem. DATE OF BURIAL 6/12/1923

20 UNDERTAKER David Sondheim ADDRESS 118 W. Mt Royal Ave

Be sure information should be carefully supplied. Each statement should be so that it may be properly classified. Write plainly in ink. Use terms, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D76597

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76597

CERTIFICATE OF DEATH.

REGISTERED NO. 78

1 PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Eva Williams

(a) RESIDENCE NO. 724 Grindall Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mns. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Bl.	Single

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of)

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packing House 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Charles Snowden (Address) 724 Grindle Court

15 Filed JUN 11 1923 ROBERT R. KRAUTER Registrar

Burial Permit Filed

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Febr. 19, 1923, to June 8, 1923, that I last saw her alive on June 8, 1923, and that death occurred, on the date stated above, at 4.45 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Exhaustion

? (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Epilepsy

? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unkn.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. E. Smith M. D.

, 19 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt auburn

DATE OF BURIAL June 11 1923

20 UNDERTAKER R L Parham

ADDRESS 902 Leadenhall

X. B.—Information should be carefully supplied. Note that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D76598

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76598

CERTIFICATE OF DEATH.

REGISTERED No. C 90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 325 Roland Ave ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert E Lee

(Residence in Baltimore: No. Equitable Bldg. St.; 40 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (*Write* the word.) Widower

6-DATE OF BIRTH. Sept. 12, 1876 (Month) (Day) (Year)

7-AGE, 46 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Atty at Law
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), U.S. Va md

PARENTS.

10-NAME OF FATHER, Henry A. Lee

11-BIRTHPLACE OF FATHER (State or Country), U.S. Va md

12-MAIDEN NAME OF MOTHER, Evelina H Whittington

13-BIRTHPLACE OF MOTHER (State or Country), U.S. Va md

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Lee

(Address) Edgewater Anne Co. Md

15-

JUN 11 1923 191 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 7, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

June 9, 1923 (Address) [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Easton Md., DATE OF BURIAL, June 11 1923

20-UNDERTAKER John O Mitchell ADDRESS 1201 W Fayette

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76599

CERTIFICATE OF DEATH.

45 D76599

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md Gen Hospx ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas A. Poulton.

(a) RESIDENCE No. 717 Carrollton Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Frances Rea Poulton

6 DATE OF BIRTH (month, day, and year) Sept 10 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas M Poulton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Susan Ann Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Annie Poulton

(Address) 717 N Carrollton Ave

15 Filed JUN 11 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-9-23

17 I HEREBY CERTIFY, That I attended deceased from 6-8-23, 19, to 6-9-23, 19,

that I last saw him alive on 6-9-23, 19,

and that death occurred, on the date stated above, at 3-5 Am.

The CAUSE OF DEATH* was as follows:

Toxemia. (Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis of Signoid

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 8-26-21

Was there an autopsy? None

What test confirmed diagnosis? Chemical typing

(Signed) John A Thompson, M. D.

, 19 (Address) Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	June 11 1923

UNDERTAKER	ADDRESS
John A Mitchell	801 W. Fayette

mation should be carefully supplied, so that it may be properly classified. Exact
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76600

CERTIFICATE OF DEATH.

24 182 D76600

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Off foot of Haubert St. ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rudolph Allendorf.

(a) RESIDENCE NO. 1321 Cooksie Street. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 10 yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~the late~~ Anna Allendorf.

6 DATE OF BIRTH (month, day, and year) January 27, 1885.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	4	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist helper.
(b) General nature of industry, business, or establishment in which employed (or employer) Tin Decorating Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Herman Allendorf.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Anna Allendorf. (wife). (Address) 1321 Cooksie St.

15 JUN 11 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning.
Collision between Steamer & Scow.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

June 10, 1923 (Address) 1011 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 11 1923
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Forrest

CAUSE OF DEATH to be plainly written. See instructions on back of certificate. TION is very important

Spec– 12-23-21—E.B.R.S.—400 Bks.

Glaenzer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76601

66 ~ D76601

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward S. Glenn

(a) Residence No. 1930 W. Lombard St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Carrie E Glaenzer

6-DATE OF BIRTH (month, day and year) Jan 10 1889

7-AGE. 34 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Baltimore, Md

PARENTS.

10-NAME OF FATHER, G. Glenn

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore, Md

12-MAIDEN NAME OF MOTHER, H. Dilger

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore, Md

11- (Informant) Carrie E. Glaenzer

(Address) 1930 W Lombard

15- Filed JUN 11 1923 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 9 20

17- I HEREBY CERTIFY, That I attended deceased from June 8, 1923 to June 9, 1923

that I last saw him alive on June 9, 1923

and that death occurred, on the date stated above, at 3 25 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Alcoholism

Acute Alcoholism (Delirium Tremens)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McPowell, M. D

June 10 1923 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal or Homicidal**. *See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem DATE OF BURIAL June 12 1923

20-UNDERTAKER Wm Cook ADDRESS 502 E North

In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76602

CERTIFICATE OF DEATH.

65-001

D76602

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1627 E Lanvale ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H Green

(a) RESIDENCE No. 1620 E Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 2 1905

7 AGE: Years 18 Months 2 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Edward H Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Blanche Healy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Edward H Green

(Address) 1620 E Lanvale St

Filed JUN 11 1923 ROBERT R. KRAUTER, Registrar

Geo Hartman 2214 Mayfield Ave

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1923

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1923, to June 10, 1923.

that I last saw him alive on " " 1923,

and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Leukaemia

Lymphatic Leukaemia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Tests

(Signed) George H. Hartman, M. D.

June 11, 1923 (Address) 2214 Mayfield Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem — DATE OF BURIAL: June 13 1923

20 UNDERTAKER: Williams — ADDRESS: Balto 5028 Natla

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms. See instructions on back of certificates.
TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76603

CERTIFICATE OF DEATH.

3/ D76603

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2823 Frisby ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen M Myers

(a) RESIDENCE No. 2823 Frisby ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Paul E Myers

6 DATE OF BIRTH (month, day, and year): Aug 4 1896

7 AGE: Years 27 Months 10 Days ... If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James Ross

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Martie Daiger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Paul E Myers (Address) 2823 Frisby St

15 Filed ... 19... Registrar. Walter White Jr 2803 Druid Park St

JUN 1 1923 ROBERT R. KRAUTER Deputy Health Commissioner and Ex-Officio Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10 1923

17 I HEREBY CERTIFY, That I attended deceased from July — 1920, to June 10 1923, that I last saw her alive on June 10 1923, and that death occurred, on the date stated above, at 5 9 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Walter H White Jr. M. D.

6/11, 1923 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: June 13 1923

UNDERTAKER: William Cook

ADDRESS: 5028 Natha...

mation should be carefully supplied, so that it may be properly classified. Each question must be answered. CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

D76604 HEALTH DEPARTMENT—CITY OF BALTIMORE D76604

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 917 Bevan St. (St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophia Seidling.

(a) RESIDENCE NO. 917 Bevan Street. (St.) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 5 mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a If married, widowed, or ~~divorced~~ — (or) WIFE of Henry Seidling.

6 DATE OF BIRTH (month, day, and year) December 25, 1850.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	5	15.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Beck.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Henry Seidling. (son). (Address) 917 Bevan St.

15 Filed JUN 11 1923, 192 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9th, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M Reinhardt (Coroner), M. D.

June 10, 1923. (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet DATE OF BURIAL June 11 1923

20 UNDERTAKER Wm Cook & Son ADDRESS North

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 llks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76605 — 31 — D76605

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Bolek -

(a) RESIDENCE. NO. Mt Hope Retreat ST.? S WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. 0 ds. How long in U. S., if of foreign birth? 20 yrs. 10 mos. 20 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Bolek

6 DATE OF BIRTH (month, day, and year) Lord Knew

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	25or18yrs -		—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer - OW

(b) General nature of industry, business, or establishment in which employed (or employer) Laboring (?)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) (?) Russia

PARENTS

10 NAME OF FATHER Peter Bolek -

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lord Knew

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Probably Russia -

14 Informant (Address) Records of Mt Hope Retreat Md -

15 Filed JUN 11 1923 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1920, to June 10, 1923, that I last saw h[illegible] alive on June 9, 1923, and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Chr Pul - Tuberculosis

abt 3or4yrs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hem Dys. Dyspnea

abt (duration) 2 yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? N Date of

Was there an autopsy? N

What test confirmed diagnosis?

(Signed) Frank Flamer, M. D.

, 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prot. Holy Cross	June 12 1923
20 UNDERTAKER	ADDRESS [illegible]

Parker-Parker, Eager

NATURE SHOULD BE STATED IN PLAIN TERMS, so that it may be properly classified. CAUSE OF DEATH in plain terms. so that it may TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76606

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76606

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST. 9 WARD)

2-FULL NAME John F. Kirwan

(a) RESIDENCE NO. Franklin & Taylor Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co.

PARENTS

10 NAME OF FATHER Wm. L. Kirwan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Emma L. Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Wm. L. Kirwan (Address) Same

15 Filed JUN 11 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9, 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1923. to June 9, 1923.

that I last saw him alive on June 9, 1923.

and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Septic sore throat

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia. (Secondary) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

(Signed) Frank C. Marino, M. D.

Jun 10. 1923 (Address) 1300 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn DATE OF BURIAL June 12 1923

UNDERTAKER Herbert Kirkler ADDRESS 1737 Eager

mation should be carefully supplied, so that it may be properly classified. Exact
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Howard

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76607

CERTIFICATE OF DEATH.

111-001 D76607

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 N Fremont St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Frank R. Howard

(a) RESIDENCE NO. see above ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) Mch 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Marble Yard

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Clara Palmer

(Address) 407 N Fremont Ave

15 Filed JUN 11 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1923

17 I HEREBY CERTIFY, That I attended deceased from May 11-23, 19 to 6-8-23, 19

that I last saw him alive on 6-1-23, 19

and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastroenteritis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Gastric Ulcer, Heart Disease (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. H. Baidecker, M. D.

6-8-1923 (Address) 15 E 12th Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn DATE OF BURIAL June 11 1923

20 UNDERTAKER John H. Jordan ADDRESS 142 Mulberry St

N. B.—Information should be carefully supplied. Each statement should be properly classified. Exact statements of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

163006
D76608

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D76608

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. " " " ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Mc Cormack.

(a) RESIDENCE No. 2706 Oak St. City · ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Marie Mc Cormack (wife)

6 DATE OF BIRTH (month, day, and year) Feb. 15, 1891.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	32	3	25.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffer.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Thomas Mc Cormack.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Louisa Schafferman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Brooks

15 JUN 11 1923 ROBERT R. KRAUTER Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1923

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1923, to June 9, 1923, that I last saw him alive on June 9, 1923, and that death occurred, on the date stated above, at 6 00 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

Bronchopneumonia, Bronchiectasis

Multiple Pul. Abscess.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not to my knowledge

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Chas. W. Cumming M. D.

, 19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: 6/12 1923

UNDERTAKER: J. J. Moran ADDRESS: 300 E Baltimore

mation should be carefully written, so that it may be properly classified. EARLY
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76609 ✓ 129 D76609

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 S. Washington ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah V. Pistel

(a) RESIDENCE No. 119 S. Washington ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. H. Pistel

6 DATE OF BIRTH (month, day, and year) Apr. 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	80	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Wm. Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Susahana Dickey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Helen V. Pistol

(Address) 119 S. Washington

15 Filed JUN 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7th 1923.

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1921, to June 7, 1923.

that I last saw her alive on June 7, 1923

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) ~ ~ ~

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical & Laboratory

(Signed) Geo. Keller M. D.

6-10, 1923 (Address) 1937 Jonquil St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Loudane Cemetery

DATE OF BURIAL 6/11 1923

20 UNDERTAKER J. A. Moran

ADDRESS 300 E. Baltor.

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on back of certificates.

D76610

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76610

CERTIFICATE OF DEATH.

177

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Grace Hall

(Residence in Baltimore: No. 1622 Federal St. St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (write word.)
female	white	married

6-DATE OF BIRTH. May 17/1884 (Month) (Day) (Year)

7-AGE. 39 yrs. 11 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Pantry woman
(b) General nature of industry, business, or establishment in which employed (or employer): Hotel 086

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS

10-NAME OF FATHER. Wm. S. Walton

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Mary L. Giddings

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Hall

(Address) 13300 Bl. Maryland Ave

15- Filed JUN 11 1923 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 7/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema- Bromide Intox.

-self administered, over dose

(autopsy at hospital)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Alcoholism

.....(Duration).....yrs.....mos.....ds.

(Signed) J S Wallace M. D. (Coroner)

6/11/23 192 (Address) 108 E Fort Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. London Park DATE OF BURIAL. June 11 1923

20-UNDERTAKER. E A Weedfield Jr ADDRESS 301 E 22 St

N. B.—Every question must be properly answered. Write plainly in ink. Do not use lead pencil. Do not use abbreviations or ditto marks. Do not leave any blanks. Be sure to state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. The information requested in this certificate is very important.

D76611

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D76611

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4025 Greenmount Ave. St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose I. Lannon

(Residence in Baltimore: No. 4025 Greenmount Ave St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
fenale	white	Widow

6-DATE OF BIRTH. December 17/1874. 1.....
(Month) (Day) (Year)

7-AGE. 49 yrs. 6 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country.) Balto. Md.

PARENTS:

10-NAME OF FATHER. John Bradley

11-BIRTHPLACE OF FATHER. (State or Country.) Ireland

12-MAIDEN NAME OF MOTHER. Anna McCarron

13-BIRTHPLACE OF MOTHER. (State or Country.) Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Eugene Lannon

(Address) 4025 Grenmount Ave.

15- JUN 11 1923 ROBERT R. KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 8/23 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Insuffiency

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Probably Chronic Myocarditis (Duration) .....yrs. .....mos. .....ds.

(Signed) E. S. Potter M. D.
(Coroner.)

6/11/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Greenmount Cathedral DATE OF BURIAL. June 13 1923

20-UNDERTAKER. E. A. Wedefeld ADDRESS 501 E 22nd

N. B.—Every question must be answered, so that it may be properly entered in the record of certificate. State CAUSE OF DEATH in plain terms, so that it may be properly coded. Information is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76612 ...

CERTIFICATE OF DEATH.

14001 ✓ D76612

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 732 W. Cross ST.. 21 WARD)

2-FULL NAME Charles A Leader

(a) RESIDENCE NO. 732 W. Cross ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie G. Leader

6 DATE OF BIRTH (month, day, and year) Dec 28 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paint Grinder

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Poppleim

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER August Leader

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Annie G. Leader
(Address) 732 W. Cross St

15 JUN 11 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1921, to June 7, 1923 that I last saw him alive on June 7, 1923 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. R. Campbell M. D.

June 9, 1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 11, 23

20 UNDERTAKER Wm. J. Pickus Son ADDRESS Norwood Ave

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76613

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76613

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 S. Eden St. ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Bernstein

(a) RESIDENCE NO. 14 S. Eden St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob J. Bernstein

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER H. K. Nelk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Shamada —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jacob J. Bernstein

(Address) 14 S. Eden St

JUN 11 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1923

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1923, to June 10, 1923, that I last saw h-r alive on June 10, 1923, and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus Acute

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma —

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) [illegible], M. D.

, 19 (Address) 125 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL June 11 1923

ADDRESS

20 UNDERTAKER Jack Levin's 1439 E Balto St

mation should be carefully supplied, so that it may be properly classified. EARLY
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

FILMED

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76614

CERTIFICATE OF DEATH.

162 D76614

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 48 Russell St. Int'n Hospital ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas Mitchell

(Residence in Baltimore: No. 48 Russell St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	Col'd	

6-DATE OF BIRTH, 6 (Month) 7 (Day) 1823 (Year)

7-AGE, ...yrs. ....mos. 3 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): Gen'l

9-BIRTHPLACE, (State or Country), U.S. Russell St

PARENTS.

10-NAME OF FATHER, Joseph Mitchell

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Laura Blue

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Mitchell

(Address) 48 Russell St Int Hospital

15 JUN 11 1923, 191.... ROBERT R. KRAUTER, Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 6 (Month) 10 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 6-7-1923, to 6-10-1923, that I saw him alive on 6-9-1923, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows: Hemorrhage of Bowel Acute

(Duration) ....yrs. ....mos. 14 hours ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) W Hall M. D.

....., 191... (Address) Hollins St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mt Auburn Cemetery	June 11, 1923
20-UNDERTAKER	**ADDRESS**
Wm Gerhold	1216 W. Baltimore

CAUSE OF DEATH in plain terms. If child, state whether born alive. Fill all blanks. Be particular and write plainly. Every certificate is important. See instructions on back of certificate.

D76615

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76615

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 5435 Bland Ave. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Robert L. Krauss

(Residence in Baltimore: No. 5435 Bland Ave St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Nov. (Month) (Day) 19 (Year)

7-AGE. 4 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto City

PARENTS.

10-NAME OF FATHER. Samuel Krauss

11-BIRTHPLACE OF FATHER. (State or Country) Balto City

12-MAIDEN NAME OF MOTHER. Pearl Hiser

13-BIRTHPLACE OF MOTHER, (State or Country) Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Krauss

(Address) 5435 Bland

15- Filed JUN 11 1923 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 8 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbuncle

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. Thos. Hossen M. D. (Coroner)

June 9 1923 (Address) 2631 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Woodlawn DATE OF BURIAL. June 11 1923

20-UNDERTAKER. Martin Eschenlohr ADDRESS 1827 W North

Kodak

state CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificate. This is very important.

Spec.—1-10-21—M&T—1500 Blks.

D76616

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76616

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO.) U.S.VETS. HOSP. #56 Ft. Mc Henry, Md. ST., 8 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME SWOBODA, Julian M.

(a) RESIDENCE NO. 1627 Lafayette Ave., Balto. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~WIFE of~~
Mrs. Julian Swoboda

6 DATE OF BIRTH (month, day, and year) ---

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27	--	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Paper hanger
(b) General nature of industry, business, or establishment in which employed (or employer): unknown
(c) Name of employer: unknown

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

PARENTS
10 NAME OF FATHER: unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown
12 MAIDEN NAME OF MOTHER: unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant (Address): Hosp. records, Ft.McHenry.

15 Filed JUN 11 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 19 23

17 I HEREBY CERTIFY, That I attended deceased from 5-3-23, 19 . to 6-9-23, 19 .
that I last saw him alive on 6-9-23, 19 ,
and that death occurred, on the date stated above, at 6:10 P. m.
The CAUSE OF DEATH* was as follows:

Pulmonary T.B. active.

3 yrs (duration) yrs. mos ds.
CONTRIBUTORY (Secondary) T.B. pulmonary active. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Laboratory and clin.
(Signed) H.H.Barker, Surg. (R) M. D.
6-11-19 23 (Address) U.S.Vets. Hosp. #56

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery — DATE OF BURIAL June 11 1923
20 UNDERTAKER: J. Fuhrmann & Son — ADDRESS 112 E Baltimore

mation should be entered, supplied, so that it may be properly classified. Exact
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76617

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 V

D76617

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 Ostend ST., 21 WARD)

2-FULL NAME Elizabeth Geik

(a) RESIDENCE NO. 409 Ostend ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 7 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept-30-1915

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	7	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... School Child

(b) General nature of industry, business, or establishment in which employed (or employer) Student

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Michel Geik

11 BIRTHPLACE OF FATHER (city or town) Hungary
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Kalinezak

13 BIRTHPLACE OF MOTHER (city or town) Hungary
(State or country)

14 Informant Michel Geik
(Address) 409 Ostend

15 JUN 11 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-11 1923

17 I HEREBY CERTIFY, That I attended deceased from 5-21, 1923, to 6-11, 1923, that I last saw her alive on 6-10, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia
& osteomyelitis of ankle joint Tibia.

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 6-2-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical

6 (Signed) 22 J. Deuane [illegible], M. D.

19 (Address) 1604 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harford Holy Cross Rd. Bel Air DATE OF BURIAL June 13 1923

20 UNDERTAKER John G. Cowgill & Son ADDRESS Jos. Hallam
By J. G. Cowgill

mation should be carefully written in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76618 D76618 161-00 D76618

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 3 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ...

2-FULL NAME Baby Pearilli

(a) RESIDENCE NO. 2175 S. High ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of Industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Charles

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Emelia Pepe

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant JOHNS HOPKINS HOSPITAL (Address) Robert F. Harrison

15 Filed JUN 11 1923, 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1923

17

I HEREBY CERTIFY, That I attended deceased from May 30 1923, to June 3 1923, that I last saw he alive on June 3 1923, and that death occurred, on the date stated above, at 1 05 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) — yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? Yes Post mortem examination

What test confirmed diagnosis? Gross appearances

(Signed) Lorliam H. Warthen, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JUN 11 1923

mation should be carefully applied, so that it may be properly classified. Each
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76619

D76619

CERTIFICATE OF DEATH.

33

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 20 WARD)

2-FULL NAME Mary Adams

(a) RESIDENCE NO. House of Good Shepherd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Belle Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address) M.T.H.

15 Filed JUN 11 1923 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1923, to June 8, 1923,

that I last saw her alive on June 8, 1923,

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous peritonitis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 4-27-23.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Francis L. Dadaglieca M. D.

6-8-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL JUN 11 1923

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

Commissioner of Health

mation should be entered, so that it may be properly classified. Letters
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

N 11 1923

Spec– 12-23-21–E.B.R.S.–400 Bks.

D76620

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76620

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph R. Eney

(a) Residence No. 2014 W. Saratoga St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 11 mos. 22 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Eney

6-DATE OF BIRTH (month, day and year) 1843 June 19

7-AGE: 79 yrs. 11 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer: Maryland Club

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md.

PARENTS:

10-NAME OF FATHER: Jeremiah Eney

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore, Md.

12-MAIDEN NAME OF MOTHER: Hester ?Meade

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Chestertown ? Md.

14-Informant: Municipal Hospital Records

(Address)

15-Filed ..... 192.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

JUN 11 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 9, 1923

17- I HEREBY CERTIFY, That I attended deceased from April 15 1923 to June 9 1923 that I last saw h. im alive on June 8 1923 and that death occurred, on the date stated above, at 12:40 A.M.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease and Cerebral arterio sclerosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis (Duration) 15 yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. M. Powell M. D.

6-9- 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: June 13, 1923

20-UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North Ave

Should be filled in plain terms, so that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76621 D76621

CERTIFICATE OF DEATH.

X 88-101 24

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General ST., Hospital WARD)

2-FULL NAME Thomas H. Wisner.

(a) RESIDENCE NO. Glen Burnie A. A. Co. Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ---yrs. ---mos. ---ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) May 21, 1899.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	---	19.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brakesman,
(b) General nature of industry, business, or establishment in which employed (or employer) B & O R R Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Glen Burnie
(State or country) A A Co Md.

PARENTS

10 NAME OF FATHER Henry D. Wisner.

11 BIRTHPLACE OF FATHER (city or town) Carroll Co.
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary E. Wolf.

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co Md.
(State or country)

14 Informant Birdie Wade. (sister).
(Address) Glen Burnie A A Co. Md.

15 Filed N 11 1923, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9th, 192 3.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
R R Accident.
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

June 10, 192 3 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? Henrietta St. B & O R R Tracks. June 9, 1923.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL June 12 192 3

20 UNDERTAKER Wm J Tickner & Sons ADDRESS N & Pa

CAUSE OF DEATH to be plainly written. Consult physician before signing. See instructions on back of certificate. ATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D76622

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76622

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH.

CITY OF BALTIMORE: (No.) 1938 W Fairmount ave ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline F. Pausch

(a) RESIDENCE No. 1938 W. Fairmount ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of): John H Pausch

6 DATE OF BIRTH (month, day, and year): Mar 6th 1837

7 AGE — Years: 86 — Months — Days — If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Louise Pausch

(Address): 1938 W Fairmount ave

15 N 1 1923

19

Robert P. Harrison,

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10 1923

17

I HEREBY CERTIFY, That I attended deceased from May 2 — 1921, to June 10, 1923

that I last saw her alive on June 10, 1923

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Senility)

(duration) 2 yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) R. Miller Hemming M. D.

6/11, 1923 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: June 12 1923

20 UNDERTAKER: Henry Lutz — ADDRESS: 203 N. Broadway

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76623

D76623

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 Little Monument ST.: 11 WARD)

2-FULL NAME Henrietta Kelley

(a) RESIDENCE. No. 707 Little Monument ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Kelley

6 DATE OF BIRTH (month, day, and year) Dec 4 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer): General

(c) Name of employer: At Home -

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Joseph Young -

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dont Know

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dont Know

14 Informant: Mrs. Kelly Sewin Room
(Address) 707 Little Monument

15 Filed JUN 11 1923, 19... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1923

17 I HEREBY CERTIFY, That I attended deceased from May 16 - 1923 to June 11 - 1923

that I last saw her alive on June 10 - 1923

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Hepatic Colic about (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Samuel A Bain, M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	6-13 1923
20 UNDERTAKER	ADDRESS
Arnold Eareau	Ba...

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered. Write plainly in ink. Do not use abbreviations or ditto marks. Every certificate must be signed. Read carefully the instructions on back of certificates. TION is very important. See instructions on back

D76624

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76624

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 705 N. Bruce St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Winifred Brown

(Residence in Baltimore: No. 705 N. Bruce St. St.; yrs. 5 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. Feb. 6, 1922
(Month) (Day) (Year)

7-AGE. 1 yrs. 5 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. James Brown

11-BIRTHPLACE OF FATHER. (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Ida Green

13-BIRTHPLACE OF MOTHER. (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ida Brown

(Address) 705 N. Bruce St.

15.

Filed JUN 11 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 10, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) .... yrs. .... mos. .... ds.

CONTRIBUTORY (Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) .... M. D.
(Coroner)

June 11, 1923 (Address) 130 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem. DATE OF BURIAL, 6-12-1923

20-UNDERTAKER, Daniel Easton ADDRESS 916 Baker

B—Every item of information should be given as accurately as possible, so that it may be properly examined. Be sure to state CAUSE OF DEATH in plain terms, so that it may be properly examined. Be sure to state CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76625

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76625

CERTIFICATE OF DEATH.

160

1-PLACE OF DEATH

City of BALTIMORE: (No. 437 Orchard St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Linwood Henson

(a) Residence No. 437 Orchard St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 28 1923

7-AGE. ....yrs. 2 weeks mos. ....ds. Or LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore City

PARENTS.

10-NAME OF FATHER: Wm Henson

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Va

12-MAIDEN NAME OF MOTHER: Rose Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14-(Informant): Mrs R. Henson

(Address) 437 Orchard St

15-Filed: Robert P. Harrison; Registrar.

UN 11 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 11, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 28 1923 to June 11 1923

that I last saw him alive on June 10 1923

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Insanition

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? N Date of

Was there an autopsy? N

What test confirmed diagnosis? none

(Signed) J H Claney M. D.

19 (Address) 753 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL, 1923
Mt Auburn Cem	6-13
20-UNDERTAKER: Daniel Easton	ADDRESS 976 Ea Cor

In order that this certificate may be properly classified, it should be filled out in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D76626

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D76626

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp 10 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert L. Ryan

(a) RESIDENCE NO. 1302 E. Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mrs Rose L. Ryan

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
53		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Ryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna McKenna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Rose L. Ryan

(Address) 1302 E Chase St

15 JUN 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1923 to June 11, 1923, that I last saw him alive on June 11, 1923, and that death occurred, on the date stated above, at 12.15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Craigen M. D.

, 19 (Address) St. Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	June 13 1923
20 UNDERTAKER	ADDRESS
Henry Adams, Bar	1301 E Lexington

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms. See instructions on back of certificates.
TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76627 D76627

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 3 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Barry

(a) RESIDENCE NO. 329 S. Caroline St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER John Barry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Municipal Hospital Records
(Address)

15 JUN 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1923

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1923, to June 10, 1923, that I last saw him alive on June 9, 1923 and that death occurred, on the date stated above, at 9:25 A.M.

The CAUSE OF DEATH* was as follows:

Senility
Hypertrophied Prostate
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia
(Terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McPowell, M. D.

6-11-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents Cemetery	6/11 1923
20 UNDERTAKER	ADDRESS
George J Ruth	1735 Harford Av

mation should be carefully supplied. Exact information
• CAUSE OF DEATH in plain terms, so that it may be properly classified.
•. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76628

CERTIFICATE OF DEATH.

1/H-002 D76628

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1739 McCulloh ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan M. Bruce

(a) RESIDENCE NO. 1739 McCulloh ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H. Bruce

6 DATE OF BIRTH (month, day, and year) July 4, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Private

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Annapolis Md

12 MAIDEN NAME OF MOTHER Matilda Ennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Md

14 Informant Grace Bruce
(Address) 1739 McCulloh St

15 JUN 12 1923 ROBERT R. KRAUSER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 8th 1923. to June 8th 1923.

that I last saw her alive on June 8th 1923.

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. 2 mos. 15 ds.

CONTRIBUTORY (Secondary) Hard Work

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

6/8. 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem. DATE OF BURIAL June 12 1923

20 UNDERTAKER Samuel T. Hemsley ADDRESS 578 W. Baltimore St.

mation should be carefully compiled, so that it may be properly classified. Exact information is required in every case. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is required in every case. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76629

CERTIFICATE OF DEATH.

101-001

D76629

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 Calhoun St., ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Henry Carr

(a) RESIDENCE. NO. 647 W. Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 28 / 81

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	0	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Grafton W. Va

PARENTS

10 NAME OF FATHER John H Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Martha Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Johnston
(Address) 607 Calhoun St.

15 FILED JUN 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1923

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1923, to June 9, 1923, that I last saw him alive on June 9, 1923, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 647 W. Lombard St.

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Harry E. Wilson M. D.

, 19 (Address) 3 W. Biddle St.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bolle. Cemetery	June 12/23

20 UNDERTAKER	ADDRESS
Liston T. Fussell Haugh	2620 St Paul

CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D76630

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76630 1923 J 1 72

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 Cole Ave. Ro[illegible] ST. [illegible] (WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Penschmidt.

(a) RESIDENCE No. 19 Cole Ave. Roslyn ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Penschmidt

6 DATE OF BIRTH (month, day, and year) April 8th 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md.

PARENTS

10 NAME OF FATHER Conrad Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Bennick

13 BIRTHPLACE OF MOTHER (city or town) Bel Air (State or country) Md.

14 Informant John Penschmidt (Address) 19 Cole Ave Roslyn

15 JUN 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1923

17

I HEREBY CERTIFY, That I attended deceased from Feby 15 1923 to June 11 1923

that I last saw her alive on June 11 1923

and that death occurred, on the date stated above, at 11.25 P. m.

The CAUSE OF DEATH* was as follows:

Bright Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Leoma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urine Chr

(Signed) W. S. Sage M. D.

(Address) 709 E. Edway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	June 14 23
20 UNDERTAKER	ADDRESS
Fred'k Lee & Son	Fullerton

mation should be carefully supplied. Blanks must be properly classified. Data should be obtained from family records, if possible. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec- 12-23-21- E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76631

CERTIFICATE OF DEATH.

89 D76631

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4901 Ferndale Av St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Dorsey Mentzel

(a) Residence No. 4901 Ferndale Av St., 28 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 6 mos. 7 ds. How long in U. S., if of foreign birth? 72 yrs. 6 mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret R. Mentzel

6-DATE OF BIRTH (month, day and year) Dec-2-1850

7-AGE, 72 yrs. 6 mos. 7 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Merchant

(b) General nature of Industry, business, or establishment in which employed (or employer) Paper Business

(c) Name of employer Self

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Mentzel

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Rachel Dorsey

13-BIRTHPLACE OF MOTHER (city or town) Howard Co (State or Country), Maryland

14- (Informant) Miss Maude S. Mentzel (Daughter)

(Address) 4901 Ferndale Ave

15- Filed JUN 12 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 9, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 8 1923 to June 9 1923

that I last saw him alive on June 9 1923

and that death occurred, on the date stated above, at 9:02 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(Duration) 5 yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) A. C. Simmons M. D.

(Address) June 9, 1923

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemy — DATE OF BURIAL June 12 1923

20-UNDERTAKER STREET & MOWEN COMPANY — ADDRESS 103 W. NORTH AVE

(Signature E. MOWEN, Secretary)

In order to secure uniformity, please write in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76632

CERTIFICATE OF DEATH.

44 D76632

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 E 28th ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence Kurzmann Sr

(a) RESIDENCE NO. 613 E 28th ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of ~~(or) WIFE of~~ Emma V Kurzmann

6 DATE OF BIRTH (month, day, and year) May 5th 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71 ~~72~~	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor & Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Lawrence Kurzmann

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Klein

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Emma V. Kurzmann
(Address) 613 E 28th st

15 JUN 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 22 1923 to June 11 1923

that I last saw ~~him~~ alive on June 10th 1923

and that death occurred, on the date stated above, at 1140 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Secondary (duration) yrs. ? mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic & Clinical Evidence

(Signed) Ray B Kolb, M. D.

June 13/23 (Address) 1203 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	June 14th 1923
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument

mation should be carefully supplied. Fill
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76633

CERTIFICATE OF DEATH.

129 D76633

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 Argyle ave ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Basil Holland

(a) RESIDENCE NO. 932 Argyle ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah A Holland

6 DATE OF BIRTH (month, day, and year) April 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Sarah Holland

(Address) 932 Argyle ave

15 JUN 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1923

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1923, to June 11, 1923, that I last saw h alive on June 13, 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Edema, Nephritis

(duration) yrs. mos de.

CONTRIBUTORY (Secondary) Expiration

(duration) yrs. mos. de.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Chas E. Mears, M. D.

6/11, 19 (Address) 1100 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	June 15 1923
20 UNDERTAKER	ADDRESS
Jarrett & Wright	1691 Pa ave

mation should be carefully supplied. Any CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76634

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D76634

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 42 S Stockton ST., 18 WARD)

2-FULL NAME Otho Stevenson

(a) RESIDENCE NO. 42 S. Stockton ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ✓ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Mar.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Va

9 BIRTHPLACE (city or town) .....
(State or country) Va

PARENTS

10 NAME OF FATHER Thos Stevenson

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Stevenson

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Va

14 Informant Sadie L. Stevenson
(Address) 1111 Madison Ave

15 JUN 12 1923 ROBERT H. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-9-1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to June 10, 1923, that I last saw him alive on June 9, 1923, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 9 yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Pulm Edema
(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Microscopic, M. D.

(Signed) .....

1923 (Address) 1339 N Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 6-12 1923

20 UNDERTAKER David Easton

ADDRESS 916 Gay ave

mation should be carefully supplied. Exact statement of cause of death may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

D76635

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D76635

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 3d Nwolfe ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah L. Norfack

(a) RESIDENCE NO. 21 3d Nwolfe ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sundain

6 DATE OF BIRTH (month, day, and year) 6/2/1859.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	—	7.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Alexander Lowry.

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Margaret Reineker

13 BIRTHPLACE OF MOTHER (city or town) Germany. (State or country)

14 Informant Mrs. Doug. Kerger (Address) 21 3d Nwolfe St

15 JUN 12 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 19 23

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1923, to June 10, 1923, that I last saw h.r alive on June 9, 1923 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Disease of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Crenshaw, M. D.

6/11, 1923 (Address) 517 Lock St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview Cemy — DATE OF BURIAL 6/12/1923

20 UNDERTAKER J. F. Bakes Sons — ADDRESS 318 Light St

mation should be carefully supplied. Exact
so that it may be properly classified.
CAUSE OF DEATH in plain terms, so th
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Haiger

D76636 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D76636

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital 96 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora M. Haiger

(a) RESIDENCE No. 107 So. Fifth St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John G. Haiger.

6 DATE OF BIRTH (month, day, and year) May 16 - 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	45	0	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER George Fleischmann

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Geist

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant John G. Haiger

(Address) 107 S. 5th St.

15 JUN 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-10-1923

17 I HEREBY CERTIFY, That I attended deceased from 5-31-, 1923, to 6-10-, 1923,

that I last saw her alive on 6-10, 1923

and that death occurred, on the date stated above, at 6 00 A m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Cardiac Dropsy

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X ray

(Signed) Newton A Burn, M. D.

, 19 (Address) Franklin Sq Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL June 12 1923

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Wolfe St.

N. B. All information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76637

CERTIFICATE OF DEATH.

169 D76637

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Body found floating in Spring Gardens. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Gerbig.

(a) RESIDENCE NO. 3010 Edmondson Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. 3 mos. 7 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, HUSBAND of Catherine C. Gerbig.

6 DATE OF BIRTH (month, day, and year) March 2nd. 1889.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	3	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Secretary,
(b) General nature of industry, business, or establishment in which employed (or employer) Colonial Trust Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles H. Gerbig.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary E. Brannan.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant (Address) Charles H. Gerbig. (father) 2215 Wilkens Ave.

15 JUN 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June, 9th. 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

June, 10th 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL June 13 1923

20 UNDERTAKER Harry N. Annacost — ADDRESS 420 Ridgewood Ave

CAUSE OF DEATH is plain terms, so that a person without medical training can understand it. Do not use abbreviations or technical terms. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76638

CERTIFICATE OF DEATH.

129 D76638

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1737 E Pratt (St.) 2 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William T. Lyston

(a) RESIDENCE. NO. 1737 E Pratt ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Lyston

6 DATE OF BIRTH (month, day, and year) Dec 22 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron molder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Michael Lyston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Erland

12 MAIDEN NAME OF MOTHER Isabell Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Erland

14 Informant Catharine Lyston
(Address) 1737 E Pratt

15 JUN 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1923

17 I HEREBY CERTIFY, that I attended deceased from June 1 1923, to June 10 1923.

that I last saw h— alive on June 9 1923.

and that death occurred, on the date stated above, at 10/7 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

June 12 1923 (Address) 14 So Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 13 1923
20 UNDERTAKER	ADDRESS
Wendell Dippel & Son	378 Hmm

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

164054
D76639

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76639

CERTIFICATE OF DEATH.

REGISTERED NO. 56

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hos. ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Odella Gross

(a) RESIDENCE No. 2809 Simpson St., ST., City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~mos.~~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 7 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Eugene

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Johns Hopkins Hospital Records

15 JUN 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1923

17 I HEREBY CERTIFY, That I attended deceased from May 30 1923. to June 3 1923.

that I last saw her alive on June 3 1923.

and that death occurred, on the date stated above, at 3.45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic gastric indigestion

(duration) 0 yrs. 7 mos — ds.

CONTRIBUTORY (Secondary) Rickets and Tetany

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of —

Was there an autopsy? Yes Post mortem examination of organs.

(Signed) William H. Welch M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS JUN 12 1923

mation should be entered. Each question must be answered in full, and the word "unknown" or the abbreviation "unk." may be properly classified. Exact information is required in every case. Additional space for answers is given on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is required in every case. Additional space for answers is given on back of certificates.
TION is very important. See instructions on back of certificates.

186

Spec- 12-23-21—E.B.R.S.—400 Bks.

D76640 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-091 D76640

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2219 Druid Hill Ave Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura J Amos

(a) Residence No. 2219 Druid Hill Ave St. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. Life How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of James H Amos

6-DATE OF BIRTH (month, day and year) Nov 16/1846

7-AGE. 76 yrs. 6 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Nothing

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country) Maryland

PARENTS.

10-NAME OF FATHER. George Woods.

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER. Salsanna Short

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) Sarah G Klein

(Address) 2219 Druid Hill Ave

15-

Filed JUN 12 1923 19.. ROBERT R. KRAUS, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 10 1923

17- I HEREBY CERTIFY, That I attended deceased from June 5 1923 to June 10 1923.

that I last saw h.. alive on June 9 1923.

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Bronchs Pneumon

(Duration) yrs. 3 mos. 5 ds.

CONTRIBUTORY (Secondary) pulmonary edema

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) W S Love M. D.

, 19 (Address) 836 W. North av

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Western DATE OF BURIAL. June 12.. 1923

20-UNDERTAKER. Isaiah Dyson ADDRESS 1600 W North

Instructions: Answer questions in plain terms, so that it may be properly classified. Follow instructions on back of certificates.

D76641 HEALTH DEPARTMENT—CITY OF BALTIMORE D76641

CERTIFICATE OF DEATH. 182

1-PLACE OF DEATH City of BALTIMORE: (No. Pellotts Wharf Foot Chester St Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Antoni Wlo Kowski

(Residence in Baltimore: No. 2230 Cambridge St St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. Unknown (Month) (Day) (Year)

7-AGE. 8 yrs. 5 mos. ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. Wladyslaw Wlotkowski

11-BIRTHPLACE OF FATHER. (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Maryjana Rotkowska

13-BIRTHPLACE OF MOTHER. (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wladyslaw Wlotkowski
(Address) 2230 Cambridge St

15- Filed JUN 12 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 10th 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Geo. B. Hilton M. D.
Coroner.

June 12 1923. (Address) Curtis Bay Md

*State the Disease Causing Death, or, if from Violent Causes, state (1) Means of Injury; and whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Holy Rosary Cem — DATE OF BURIAL. June 13 1923

20-UNDERTAKER. J. Fiackowski — ADDRESS 1123 Bond St

N. B.—Every question must be answered, and if it may be properly answered "None," or "Unknown," as the case may be. Do not state CAUSE OF DEATH in plain terms, so that it may be properly classified. Underlining or printing the words is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

D76642

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76642

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 N. Charles ST. 11 WARD)

2-FULL NAME Benjamin M. Heighe Jr

(a) RESIDENCE NO. 605 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 29 Jan 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	83	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Benjamin M Heighe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Anna Baldwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Jno M Heighe (Address) 605 N Charles St

15 Filed JUN 12 1923 19 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6, 10, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 , 1922 , to June 10 , 1923 , that I last saw h[illegible] alive on June 10 , 1923 , and that death occurred, on the date stated above, at 10, 01 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James C. Clark, M. D.

June 10, 1923 (Address) Latrobe Apt, Charlesea 4/12

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem — DATE OF BURIAL: June 12 1923

20 UNDERTAKER: Henry H. Jenkins Sons — ADDRESS: McCulloh & Orchard

mation should be given, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76643

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3T D76643

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST. 16 WARD)

2-FULL NAME Elizabeth Hudson

(a) RESIDENCE NO. 1028 Calhoun st. ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Wiggins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) M.T.H.

15 JUN 12 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1923

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1923, to June 9, 1923,

that I last saw her alive on June 9, 1923,

and that death occurred, on the date stated above, at 3.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dadaylucca M. D.

6-9-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. [illegible] Burial	June 12, 1923
20 UNDERTAKER Samuel M. Cheaney	ADDRESS 1400 Mosher

N.B.—Blanks should be carefully supplied. Information should be carefully classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec—12-23-21—E.B.R.S.—400 Blks.

D76644

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76644

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

City of BALTIMORE: (No. Dennison & Mondawmin ave. St., N. E. Corner 15 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Missouri N. Sanderson

(a) Residence No. Dennison & Mondawmin ave. St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 7 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Francis Sanderson

6-DATE OF BIRTH (month, day and year) Nov 6. 1848

7-AGE. 74 yrs. 7 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... retired

(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto. Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... "
(State or Country),

12-MAIDEN NAME OF MOTHER, "

13-BIRTHPLACE OF MOTHER (city or town)..... "
(State or Country).

14- (Informant) Leonard R. Mollett

(Address) Dennison & Mondawmin

15- Filed ..... 19..... Registrar

JUN 12 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 11. 23

17- I HEREBY CERTIFY, That I attended deceased from May 14th, 1923, to June 11, 1923, that I last saw h[illegible] alive on June 10th, 19 23, and that death occurred, on the date stated above, at 4:15 a.m.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 27 ds.

CONTRIBUTORY (Secondary) Paralysis

(Duration) ..... yrs. ..... mos. 27 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Herbert E. Zepp M. D.

June 12 1923 (Address) 3048 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park DATE OF BURIAL, June 13 1923.

20-UNDERTAKER. John O'Neill ADDRESS 120 W. Fayette St.

Shading to be used in plain terms, so that it may be properly classified. Exact statements as to instructions on back of certificates.

D76645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76645

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 16 So. Bethel St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt Williams

(Residence in Baltimore: No. 16 So. Bethel St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: ~~White~~ Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Unknown (Month) (Day) (Year)

7-AGE: About 27 yrs. — mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Va

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

15- Filed ..... 192.....

Robert F. Harrison
Registrar.

Burial Permit Given

JUN 12 1923

0464 THE MORGUE.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 7th 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest or no Inquest.) thereon and from the evidence obtained by said Inquest (Inquest or Autopsy or Inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage Lungs
about 10 Min (Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) Pneumonia
..... Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. B. Johnson M. D.
(Coroner)
June 11th 1923 (Address) Curtis Bay Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL, ... 19....

20-UNDERTAKER. ADDRESS

JUN 12 1923

Commissioner of Health

UNIVERSITY OF MARYLAND

—Every item should be answered in ink or typewriting, so that it may be properly classified. Erasures must be explained on back of certificate.
State CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.
Is very important.

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76646

D76646

CERTIFICATE OF DEATH.

202

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George C Chelton

(a) RESIDENCE. NO. ..... ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) Somerset Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER George Chelton

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Liza Chelton

13 BIRTHPLACE OF MOTHER (city or town) Oriole Md.
(State or country)

14 Informant W. S. Swezey Ward Supt.
(Address)

15 Filed JUN 12 1923 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1923

17 I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...,
that I last saw him alive on June 8 , 1923,
and that death occurred, on the date stated above, at 12 05 P.m.
The CAUSE OF DEATH* was as follows:

Dislocation Cervical Vertebra

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hanging

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William F. Schwark, M. D.

6/8, 1923 (Address) Maryland Penitentiary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	19

20 UNDERTAKER ..... ADDRESS .....

Commissioner Health JUN 12 1923

mation should be carefully supplied. Exact statement of
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76647

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D76647

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 938 Madison av ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Sonia Gibber

(a) RESIDENCE NO. 938 Madison av ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jonathan Gibber

6 DATE OF BIRTH (month, day, and year): June 1-1856

7 AGE: Years 67 Months Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House keeper

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Clevorius Hoffendoffer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kentucky

12 MAIDEN NAME OF MOTHER: Georgiana Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): C W Gibber Rochester N Y

15 Filed JUN 12 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11 1923

17 I HEREBY CERTIFY, That I attended deceased (from 1918 to June 11 1923, that I last saw h[illegible] alive on June 9 1923, and that death occurred, on the date stated above, at 7. a m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred C Jewett M. D.

19 (Address) 2516 Pennsylvania av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: June 13 1923

20 UNDERTAKER: Chas. E Franck — ADDRESS: 807 Madison av

mation should be carefully supplied. Exact statements CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76648 ✓ D76648

D76648

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2402 N. Charles St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lily Albert Füsting

(a) Residence No. 2402 N Charles St., 12 Ward Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 4 mos. 10 ds. How long in U. S., if of foreign birth? 72 yrs. 4 mos. 10 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Chas. F. Füsting

6-DATE OF BIRTH (month, day and year) Feby-2-1851

7-AGE. 72 yrs. 4 mos. 10 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer..... none

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, Frederick Albert

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Hannie Hayner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mr. F. Erwin Füsting (Son)
(Address) 705 Falls Road Centre.

15- Robert P. Harrison, Registrar.
192

UN 12 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 12 1923

I HEREBY CERTIFY, That I attended deceased from May 1923 to June 12th 1923.

that I last saw her alive on June 12th 1923.

and that death occurred, on the date stated above, at 12.05 a.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 16 yrs. mos. ds.

CONTRIBUTORY (Secondary) Sclerosis of Coronary Arteries (Duration) 16 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What tests were made? —

(Signed) Howard Richardson M D

6/12, 1923 (Address) 26 Elysian St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cemetery DATE OF BURIAL. June, 1923

20-UNDERTAKER. Stewart & Morris Co. Wm. J. Wooden Manager ADDRESS 108 W. Mount St.

Should be carefully filled. Exact statement of facts is required, in plain terms, so that it may be properly classified. See instructions on back of certificates.

D76649

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76649

CERTIFICATE OF DEATH.

5 99 02

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1138 Low St. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Harney

(Residence in Baltimore: No. 1138 Low St. St.; yrs. 73 mos. 11 ds. 8

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write word.)
male	white	~~Single~~ Widowed

6-DATE OF BIRTH. July 18 ~~Unknown~~ 1849
(Month) (Day) (Year)

7-AGE. 73 yrs. 11 mos. 8 ds. If LESS than 1 day ....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer for City Balto. Md.
(b) General nature of industry, business, or establishment in which employed (or employer): Has not worked for 10 yrs.

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Luke Harney

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Julia Ramsey

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Harney

(Address) 1138 Low St.

15- June 12 1923

Robert P. Harrison, Registrar.
Burial Permit Clerk.

N 12 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 10/23
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(Duration) ....yrs. ....mos. ....ds.

(Signed) J S A Pattison M. D.
(Coroner.)

6/12/23 1923 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Wesley Redeem June 13 1923

20-UNDERTAKER. ADDRESS
William G Schaeffer 846 Monument

—Every CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not state CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not state mode of dying, but the disease or injury which caused death. Name contributory (secondary) causes if any. Write plainly and fill all blanks. Omit abbreviations. Punctuation is very important. See instructions on back of certificate.

SAKS

Spec.—1-10-21—M&T—1500 Bks.

D76650

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76650

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Anne Jackson Contess

(a) RESIDENCE NO. Unknown ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~ or ~~Divorced~~, Widowed, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) 1843.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
80				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Do.
(State or country)

12 MAIDEN NAME OF MOTHER Do.

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Do.

14 Informant Bay View Hospital
(Address) Baltimore, Md.

15 Filed JUN 12 1923, 19 Robert P. Harrison, Registrar
Burial ~~Permit~~ Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar. 22, 1923, to June 11, 1923, that I last saw h~~e~~r alive on June 10, 1923, and that death occurred, on the date stated above, at 12.45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senile Dementia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) H. Feldmann, M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem Baltimore	June 13, 1923
20 UNDERTAKER	ADDRESS
Jos. Rosen & Elliott	Ashland

B. Information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See Instructions on back of certificates.

KODAK

Size—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76651

D76651

CERTIFICATE OF DEATH.

Registered No. 9

1-PLACE OF DEATH

City of BALTIMORE: (No. 844 W 37 St St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Orville James

(a) Residence No. 844 W 37 St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-~~Single, Married, Widowed, or Divorced.~~ (Write the word.)

Married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 24 1923

7-AGE. yrs. 3 mos. 21 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS:

10-NAME OF FATHER John M James

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Sarah Phillips

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) John M James

(Address) 844 W 37 St

15- Filed JUN 12 1923, 192

Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 12 1923

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1923 to June 11, 1923.

That I last saw h[illegible] alive on June 11, 1923

And that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(Duration) yrs. mos. 12 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? Physical examination

(Signed) C. J. Davis M. D

6/12 1923 (Address) 800 N 33rd St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Cemetery DATE OF BURIAL, June 13 1923

20-UNDERTAKER, SHINOWEITH & SON, ADDRESS 2617 CHESTNUT AVE

Should be carefully supplied. Exact statements of facts are required in plain terms, so that it may be properly classified. Examine instructions on back of certificates.

D76652

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76652

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. St. Joseph's Hospital St. 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Solomon Whitehall

(Residence in Baltimore: No. 1639 Westwood Ave. St.; yrs. 49 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	White	married

6-DATE OF BIRTH. May 13/1874 (Month) (Day) (Year)

7-AGE. 49 yrs. mos. 29 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): Cigar Factory

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS:

10-NAME OF FATHER. Isaac Whitehall

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Sarrah Eichengreen

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Minnie Whitehall

(Address) 1639 Westwood Ave

15- Filed JUN 12 1923 192 Robert P. Harrison; Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH. June 11/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Appoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. H. Coleman M. D. (Coroner)

6/12/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Chev Shalom Cem. DATE OF BURIAL. 6/13/ 1923

20-UNDERTAKER. Baird & Warner ADDRESS 118 W. Mt. Royal Ave.

To state CAUSE OF DEATH in plain terms, so that it may be properly classified, is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76653

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76653

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Mercy Hospital St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Nicholas Leonard (Narvesen)

(a) Residence No. 3800 Hanford Ave St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 21 1853

7-AGE. 70 yrs. 7 mos. 8 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Watchman

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Norway

PARENTS.

10-NAME OF FATHER. Nordson Leonard

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Norway

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Norway

14- (Informant) Chas C Kapsody

(Address) 2700 Hanford Ave

15- Filed JUN 12 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 10 23

17- I HEREBY CERTIFY, That I attended deceased from 5-28 1923 to 6-10 1923

that I last saw h.. alive on 6-10 19 23

and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows:

Cortex Regurgitation

Syphilis (Tertiary)

(Duration) 5 yrs. mos.

CONTRIBUTORY (Secondary) Cardiac decompensation (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Sequel

(Signed) L. J. Barnard M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cem. DATE OF BURIAL. June 13 1923

20-UNDERTAKER. ADDRESS William Peck 502 E Madison

Should be carefully filled out in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76654

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76654

CERTIFICATE OF DEATH.

Registered No. 15 49

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas Von Hagel

(a) Residence No. 2707 Longwood St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) Mar 3 1866

7-AGE. 56 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Steam Fitter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, George Von Hagel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, C. Line

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto., Md.

11- (Informant) Municipal Hospital Records

(Address)

15- Filed JUN 12 1923 Robert P. Harrison, 19? Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 12, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 8 19 23 to June 12 19 23

that I last saw him alive on June 11 19 23

and that death occurred, on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung

(Duration) ? yrs. 4 mos. (Autopsy) ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. M. Powell M. D

6-12-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral DATE OF BURIAL. June 15 1923

20-UNDERTAKER. William Cook ADDRESS 502 E Balto

Should be written in ink, so that it may be properly classified. Exact statement of cause of death must be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

D76655

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76655

1-PLACE OF DEATH 1734 Scott Street dead at 191 Registered No. C.....

City of BALTIMORE: (No. Franklin Square Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Conrad Nazarenus

(Residence in Baltimore: No. 1734 Scott St St.; yrs., 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Married

6-DATE OF BIRTH, Feb 27, 1845
(Month) (Day) (Year)

7-AGE, 78 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, John Nazarenus

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER, Margaret Nunn

13-BIRTHPLACE OF MOTHER, (State or Country). md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Nazarenus

(Address) 1736 Riddley St

15-

Filed JUN 12 1923 192.

Robert P. Harrison, Registrar.

~~Burial Permit Clerk.~~

N. B.—Every item of the above must be properly answered, so that it may be properly classified. Particularly state CAUSE OF DEATH in plain terms, so that it may be properly classified. Do not use abbreviations. Every item is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 10 192 3
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet Wound through Chest just above Heart

Homicidal

(Duration) yrs. mos. 1/4 hr.

CONTRIBUTORY (Secondary) Internal Hemorrhage

(Duration) yrs. mos. ds.

(Signed) James McFarlane M. D.
(Coroner.)

June 12 192 3 (Address) 700 E Chase

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
London Park	June 13 1923

20-UNDERTAKER,	ADDRESS
Wm Cook	for E Fayette St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76656

101-001

D76656

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 644 Dover ST. 12 WARD)

2-FULL NAME James H. Lyons

(a) RESIDENCE NO. 644 Dover ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Lyons

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	50	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Marie Lyons

(Address) 644 Dover St

15 Filed JUN 13 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1923

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1923, to June 17, 1923, that I last saw him alive on June 11, 1923, and that death occurred, on the date stated above, at 6:30 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 4y ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Examination

(Signed) C. H. Hoover, M. D.

(Address) 7128 Main St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Ct — DATE OF BURIAL June 13 1923

20 UNDERTAKER J. Thos. Sherwood & Son — ADDRESS 1018 W. Baltimore

N. B. Information should be carefully supplied. Accurate information may be properly classified. Exact statements CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

Lee.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76657

CERTIFICATE OF DEATH.

4 74,001

D76657

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 228 N. Pine ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Lee

(a) RESIDENCE NO. 228 N. Pine ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sarah Terrence (Address) 228 N. Pine St.

15 Filed JUN 13 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1923

17

I HEREBY CERTIFY, That I attended deceased from June 10, 1927, to June 10, 1923, that I last saw h[illegible] alive on June 10, 1923, and that death occurred, on the date stated above, at 12.15 m.

The CAUSE OF DEATH* was as follows:

Lymphosarcoma, Cerebral Hemorrhage

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic examination

(Signed) [illegible] M. D.

June 1, 1923 (Address) 112 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	June 13 1923
20 UNDERTAKER	ADDRESS
Wm. Burns & Son	108 W. Mulberry

mation should be carefully supplied. Items must be properly classified. Entries must be typewritten or written in ink. Do not use abbreviations. CAUSE OF DEATH in plain terms, so that it may be properly classified. Entries must be typewritten or written in ink. Do not use abbreviations. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76658 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 D76658

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2731 Boston ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Britcher

(a) RESIDENCE No. 2731 Boston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Britcher

6 DATE OF BIRTH (month, day, and year) April 15, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	73	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Young & Co. 886 Philadelphia Pa.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Henry Britcher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Parks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mary Britcher (Address) 2731 Boston St

15 Filed JUN 13 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1923

17 I HEREBY CERTIFY, That I attended deceased from January 1, 1923, to June 11, 1923

that I last saw h alive on June 9, 1923

and that death occurred, on the date stated above, at 9:15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach with Metastasis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) m J M. Gray, M. D.

6/12, 1923 (Address) 839 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park DATE OF BURIAL June 13 1923

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Pennsylvania Ave

S. B. Write should be carefully supplied. Any information should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may

D76659

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 ✓

D76659

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles F. Knell

(Residence in Baltimore: No. 1232 Aisquith St. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write out the word.)
male	white	S (Write out the word.)

6-DATE OF BIRTH. April 14/1923 (Month) (Day) (Year)

7-AGE. yrs. 1 mos. 27 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, George Knell

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER, Mildred Wolfslagher

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Knell

(Address) 1232 Aisquith St.

15- Filed JUN 13 1923 19.. ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 12/23 (Month) (Day) (Year) 19..

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Possibly Pertussis (Duration) yrs. mos. ds.

(Signed) J. S. H. Culler M. D. (Coroner.)

6/12/23 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cathedral DATE OF BURIAL. June 13. 1923

20-UNDERTAKER. J. C. Medford ADDRESS 9 Belmont Ave

N. B.—Every question must be answered. If any of the above questions cannot be answered, write "unknown." Do not state CAUSE OF DEATH in plain terms, so that it may be properly understood by any one reading the certificate. Information as to time of death is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76660

D76660

CERTIFICATE OF DEATH.

31

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard M. Lawrence

(Residence in Baltimore: No. 647 N. Paca St. St.; yrs. 15 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	col.	single

6-DATE OF BIRTH. Oct. 1st 1887
(Month) (Day) (Year)

7-AGE. 35 yrs. 8 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House- man
(b) General nature of industry, business, or establishment in which employed (or employer): Hotel

9-BIRTHPLACE. (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER. Richard Lawrence

11-BIRTHPLACE OF FATHER. (State or Country). N. Carolina

12-MAIDEN NAME OF MOTHER. Martha Johnson

13-BIRTHPLACE OF MOTHER. (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bessia Fraser(sister)

(Address) 1111 Ogden St. Phila. Pa.

15- FILED JUN 13 1923 ROBERT R. KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 9/1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis
(Probably)

Reported sick 2 mons. (Duration) Yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) Yrs. mos. ds.

(Signed) Jos. H. Falk M. D.
(Coroner)

6/11/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Laurel Cem. DATE OF BURIAL. 6/13 1923

20-UNDERTAKER. Samuel J. Hensley & Bro. ADDRESS 578

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Certificate is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76661

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 101-001 D76661

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Cook

(a) RESIDENCE. NO..... ST., ... WARD. Winfield Md.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 6 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Woodstock, Md.

PARENTS

10 NAME OF FATHER John Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant C. S. Sharrer Warden
(Address)

15 Filed JUN 13 1923, 19 ROBERT R. KRAUTER, Registrar
Deputy Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1923

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1923, to June 11, 1923, that I last saw h... alive on June 11, 1923, and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation Toxemia and Exhaustion

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. 1 mos. 23 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) William F. Schwartz, M. D.

6/12, 1923 (Address) Maryland Penitentiary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cupsaw Co. Md. Fairview Cemetery.	June 14 1923
20 UNDERTAKER C. M. Watts.	ADDRESS Winfield Md.

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Coffersthil

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76662

CERTIFICATE OF DEATH.

9 D76662

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Main × Bank St., Lake WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Coffersthil

(a) RESIDENCE NO. Main × Bank ST., WARD Lakeland

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 17th 1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Walter A. Coffersthil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lydia Fentz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Walter A. Coffersthil

(Address) 3 Bunker Hill Ave. Lakewood

15 JUN 13 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1923, to June 12, 1923, that I last saw h[illegible] alive on June 11, 1923, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw Compton M. D.

6/12, 1923 (Address) 517 Lemmon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL June 13 1923

ADDRESS 1831 Lanvale

20 UNDERTAKER C. Nicholson & Son

mation should be carefully supplied. Let it may be properly classified.
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on back of certificate.

D76663 HEALTH DEPARTMENT—CITY OF BALTIMORE 89 D76663

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2417 Lauretta Ave St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Etta Berman

(Residence in Baltimore: No. 2417 Lauretta Ave St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) M

6-DATE OF BIRTH. 1865
(Month) (Day) (Year)

7-AGE. 60 y. 5 m. 24 d.
yrs. mos. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Lain Liguer

11-BIRTHPLACE OF FATHER. (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Zukauer

13-BIRTHPLACE OF MOTHER. (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) K. Berlin

(Address) 2417 Lauretta

15- JUN 13 1923 ROBERT R. KRAUTER, Burial Permit Clerk. (Registrar.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 12 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration).....yrs.....mos.....ds.

(Signed) ..... M. D.
(Coroner.)

192....(Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Hebrew Rosedale DATE OF BURIAL. 6/13 1923

20-UNDERTAKER Sol Levinson & Bro ADDRESS 1127 E Balto. St.

N. B.—Every item of information must be given, so that it may be properly classified. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Study instructions on back of certificate. Each item is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Iskowitz

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76664

CERTIFICATE OF DEATH.

74-001

D76664

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2100 E Balto St. ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Iskowitz

(a) RESIDENCE NO. 2100 E Balto St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widow

5a If married, widowed or divorced (HUSBAND) of (or) WIFE of: Jacob Iskowitz

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 69 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Family 1429 E. Baltimore St.

15 Filed JUN 13 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12 1923

17 I HEREBY CERTIFY, that I attended deceased from May 14, 1923, to June 12, 1923, that I last saw h[illegible] alive on June 11, 1923, and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): arterio-sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Whitehorne, M. D.

, 19 (Address) 810 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rodeph Shalom Cem. DATE OF BURIAL: June 13th 1923

20 UNDERTAKER: Jack Levin ADDRESS: 1429 E. Balto. St.

mation should be carefully supplied. Entry must be made in ink or indelible pencil, and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of date of birth is very important. See instructions on back of certificates.

Cor —1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76665

CERTIFICATE OF DEATH.

199 D76665

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

D76665

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 130 W. Montgomery St. ST., 22 WARD)

2-FULL NAME John B. Jones.

(a) RESIDENCE NO. 130 W. Montgomery St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ---- mos. ---- ds. How long in U. S., If of foreign birth? 20 yrs. ---- mos. ---- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Do not know.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman.
(b) General nature of industry, business, or establishment in which employed (or employer) Salvation Army.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Oscar R. Hagg.
(Address) 130 W. Montgomery St.

15 JUN 13 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9th. 1923 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest & autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of the skull.
Struck on the head by a piece of metal bibe. Homicide.
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt, M. D.
(Attending Physician or Coroner.)

June 12th 192 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery — DATE OF BURIAL June 13 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76666 | CERTIFICATE OF DEATH. | 129 | D76666

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2104 E Hoffman St. 8 (WARD)

2-FULL NAME John Henry Kerlack

(a) RESIDENCE NO. 2104 E Hoffman ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 57 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie R. Kerlack

6 DATE OF BIRTH (month, day, and year): Sept 8/858

7 AGE: Years 64 | Months 9 | Days 3 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Steam Fitter
(b) General nature of industry, business, or establishment in which employed (or employer): 060
(c) Name of employer: Heat Power Co.

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS
10 NAME OF FATHER: [illegible]
11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger
12 MAIDEN NAME OF MOTHER: Berg[illegible]
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Informant (Address): Wm H. Kerlack Sr. 2104 E. Hoffman

15 JUN 13 1922 ROBERT R. KRAUTER, Register Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11 1923

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1923, to June 11, 1923, that I last saw him alive on June 11, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis 2

(duration) yrs. 4 mos ... ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Usual

(Signed) W. S. Smith M. D.
(Address) June 13 1923 109 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park | DATE OF BURIAL: 6/14 1923

20 UNDERTAKER: Wm J Rehrmann Sons | ADDRESS: Norfolk

mation should be carefully supplied. Any that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

D76667

HEALTH DEPARTMENT—CITY OF BALTIMORE D76667

CERTIFICATE OF DEATH.

Registered No. C 113

1-PLACE OF DEATH

City of BALTIMORE: (No. 1224 Carlton St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Smith

(Residence in Baltimore: No. 1224 Carlton St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	col	single

6-DATE OF BIRTH. June 2 1923
(Month) (Day) (Year)

7-AGE, ... yrs. ..... mos. 9 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Henry Smith

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER, Jane Jones

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jane Smith

(Address) 1224 N. Carlton St.

15-

Filed JUN 13 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 10 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Hamilton Bailey, M. D.
(Coroner)

June 12 1923 (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	June 13 1923
20-UNDERTAKER. James A. Davis	ADDRESS. 503

N. B.—Every item of information must be given, so that it may be properly classified. Exact statement of cause of death in plain terms, so that it may be properly classified. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76668

CERTIFICATE OF DEATH.

128 D76668

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1131 Fremont ST., 14 WARD)

2-FULL NAME Corine Jones

(a) RESIDENCE NO. 1131 Fremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (or) ~~HUSBAND of~~ WIFE of Omri Jones

6 DATE OF BIRTH (month, day, and year) ? 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Richard Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Florence Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Omri Jones

(Address) 1131 Fremont Ave

15 JUN 13 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1922

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1922, to June 12, 1922, that I last saw her alive on June 11, 1922 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wallace Frey, M. D.

6/12, 1922 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Park, Md	June 13 1922
20 UNDERTAKER	ADDRESS 307 Fremont Ave
Wm H. Lewis	

N. B.—Information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal Condition

Cor.—1-12-23—M&T—100 Blks.

D76669

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D76669

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1028 N Lexington ST., 18 WARD)

2-FULL NAME Edward Bryant

(a) RESIDENCE NO. 1028 N Lexington St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Birth mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Do
(c) Name of employer —

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Brosie Bryant

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Eliza Williams

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant W H Jones
(Address) 1026 N Gilmor

15 Filed ..... 192 .....

JUN 13 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said ..... find that said deceased came to his death on the day stated above.
~~Inquest, autopsy or~~ Inquiry.)

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) Dont Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W H Grinnell, M. D.
(Coroner.)

June 13, 1923 (Address) 117 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL June 13 1923

20 UNDERTAKER Wm H Rose Son — ADDRESS Woodmont

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact residence of deceased TION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

Suter

D76670 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓ D76670

131

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2870 Woodbrook ave ST., 13 WARD)

2-FULL NAME Ida May Suter

(a) RESIDENCE NO. 2870 Woodbrook ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry E. Suter.

6 DATE OF BIRTH (month, day, and year) March 15-1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	43	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John F. Deilbis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Debora Megaloss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Harry E. Suter, husband
(Address) 2870 Woodbrook ave.

15 JUN 13 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11th 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 20th, 1923, to June 11th, 1923, that I last saw h.r alive on June 10th, 1923, and that death occurred, on the date stated above, at 6.10 a. m.

The CAUSE OF DEATH* was as follows:
Bilateral Pyelonephrosis; Colon Septicemia; pyelitis.

(From history) (duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) Renal insufficiency, (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? at place of death.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? X-ray, blood culture, etc.

(Signed) Chas. E. Habliston, M. D.

, 19 (Address) 1315 Mt. Royal ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Sunday

DATE OF BURIAL June 13 1923

20 UNDERTAKER W M Ronton

ADDRESS 2218 W North

mation should be carefully supplied. Exact statement of facts
that it may be properly classified.
CAUSE OF DEATH in plain terms, so that
TION is very important. See instructions on back of certificates.

Spec- 12-23-21-E.B.R.S.-400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76671

CERTIFICATE OF DEATH.

90 D76671

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Weeks

(a) Residence No. 908 Peach Alley St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1884

7-AGE. 39 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) North Carolina

PARENTS.

10-NAME OF FATHER. Willis Weeks

11-BIRTHPLACE OF FATHER (city or town) (State or Country). N C

12-MAIDEN NAME OF MOTHER. Ellen Green

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). N C

14- (Informant). Sarah Howe

(Address) 908 Peach alley

15- JUN 13 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 9, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 5, 1923, to June 9, 1923, that I last saw h[illegible] alive on June 9 1923 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Myocardial Insufficiency

(Duration) ? yrs. mos. 14 ds. (Chronic)

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. 10 ds. (Chronic)

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. McPowell M. D.

June 11, 1923 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn DATE OF BURIAL. June 13 1923

20-UNDERTAKER. R E Gross ADDRESS 1405 McElderry

Should be filled in plain terms, so that it may be properly classified. Exact residence of deceased. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76672 HEALTH DEPARTMENT—CITY OF BALTIMORE D76672

CERTIFICATE OF DEATH. 38

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St. Joseph's Hosp WARD)

2-FULL NAME Anna Dore.

(a) RESIDENCE NO. 2005 Lamby St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female. 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dan Howard Rebecker Dore

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 39 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Saint-Marys Co Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Rebecker Dore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co

14 Informant Charles S Summersill

(Address) 2005 Lamby Cust

15 Filed JUN 13 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1923. to June 10, 1923. that I last saw her alive on June 10, 1923. and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No P S & S.

What test confirmed diagnosis?

(Signed) John J. Kroger M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Saint Marys Co Md DATE OF BURIAL June 13 1923

20 UNDERTAKER Mrs Norris & Elliott ADDRESS 1725- Eastlan[illegible]

mation should be carefully supplied. Exact statement of facts may be properly classified. CAUSE OF DEATH in plain terms, so that it may be TION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76673 D76673

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1623 Shakespheare St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wladyslow Kamienski

(a) Residence No. 1623 Shakespheare St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 4/22

7-AGE. 1 yrs. 3 mos. 8 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER Wladyslaus Kamienski

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Rozalia Worek

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Wladyslaus Kamienski

(Address) 123 Shakespheare

15-

Filed JUN 13 1922 ROBERT R. KRAUTER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 12/23

17- I HEREBY CERTIFY, That I attended deceased from 6/5 19.. to 6/12 1923

that I last saw him alive on 19 23

and that death occurred, on the date stated above, at 930 P.M.

The CAUSE OF DEATH* was as follows:

Brights disease

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. J. Freedus M. D.

6/13 1923 (Address) 1918 E Fayette St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary DATE OF BURIAL. June 14 1923

20-UNDERTAKER. John M Weber ADDRESS 1803 Bank St

Directions: Fill in plain terms, so that it may be properly classified. Erase inapplicable words. See instructions on back of certificates.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 20 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Pyelonephritis

Gave a history of having

caught a cold.

Spec- 12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D76674

D76674 Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No. Municipal Hospital St., 5 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Crooks

(a) Residence No. Essex & Mott St., Ward
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year)

7-AGE. 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore, Md.

PARENTS.
10-NAME OF FATHER, ?
11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?
12-MAIDEN NAME OF MOTHER, ?
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), ?

14-(Informant) Hospital Records
(Address)

15-JUN 13 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 9, 1923

17-I HEREBY CERTIFY, That I attended deceased from June 8, 1923 to June 9 1923.
that I last saw him alive on June 9 1923.
and that death occurred, on the date stated above, at 1 30 P.M.
The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (Terminal) (Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. McPowell M. D.
June 10, 1923 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. 19...

20-UNDERTAKER. ADDRESS

Commissioner Health.

JUN 13 1923

UNIVERSITY OF MARYLAND

Should be written in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary. See instructions on back of certificates.

87

3467

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76675

REGISTERED NO. D76675

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14th St & 9th Ave. ST., 76 WARD)

2-FULL NAME Steve Stoblek

(a) RESIDENCE No. 14th St. & 9th Ave. Canton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) May 27-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3 yrs.		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) None.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canton Baltimore City Md

PARENTS

10 NAME OF FATHER Michael Stoblek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Croto-Slavia

12 MAIDEN NAME OF MOTHER Agnes Nevelan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Croto-Slavia

14 Informant Michael Stoblek

(Address) 14th St & 9th ave.

15 JUN 13 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1922

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1922, to June 12, 1922, that I last saw him alive on June 12, 1922, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos 23 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Frank A. Yeantz, M. D.

6/12, 19 (Address) 3244 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus — DATE OF BURIAL 6/13 1922

UNDERTAKER J. F. Fallon & Co — ADDRESS 1405 Eastern

N. B.—All information should be carefully supplied. Note that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76676

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

32 D76676

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 829 S Bond St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Waclaw Marszal.

(a) Residence No. 829 S. Bond St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE, Whit

5-Single, Married, or Divorced, (Write the word.) ~~Single~~

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 18 1920

7-AGE. 3 yrs. 4 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md.

PARENTS

10-NAME OF FATHER, M. Marszal.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER, Wladyslawa Makuszyk

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14- (Informant) M. Marszal

(Address) 829 S. Bond

15- Filed JUN 13 1922 ROBERT R. KRANTZ, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 9 1923

17- I HEREBY CERTIFY, That I attended deceased from June 1st 1923 to June 9th 1923

that I last saw h[illegible] alive on June 9th 1923

and that death occurred, on the date stated above, at 11.55 a.m.

The CAUSE OF DEATH* was as follows:

Brain tumor.

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Symptoms

(Signed) Amelia E. Linz, M. D

19 (Address) 1717 N. Caroline St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Rosary	6/14/ 1923
20-UNDERTAKER.	ADDRESS.
Wm Gleason's	1618 Eastern

Should be carefully supplied. Exact statement of OCCUPATIONS necessary, in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76677

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76677

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 65 E. Randall ST., 72 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Bauer

(a) RESIDENCE NO. 65 E. Randall ST. 72 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Bauer

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years 67. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER ? Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John F. Bauer

(Address) 65 E. Randall St.

15 Filed JUN 13 1923 19

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

JUN 13 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1923

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1923 to June 11, 1923.

that I last saw h alive on June 11, 1923.

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

+ Chronic Cystitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hall Evans M. D.

6/14/1923 (Address) 2 E. Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross RC

DATE OF BURIAL 6/14 1923

20 UNDERTAKER John F. Galvin Sons

ADDRESS 319 N. Eutaw St.

mation should be carefully supplied. Exact statement of OCCUPA-
that it may be properly classified.
CAUSE OF DEATH in plain terms, so that
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76678

D76678

CERTIFICATE OF DEATH.

REGISTERED NO. 731

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 402 Carroll st, Brooklyn ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Cecelia Thomas

a) RESIDENCE. No. 402 Carroll st, Brooklyn ST., WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	wh	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Owen E. Thomas

6 DATE OF BIRTH (month, day, and year) Nov 1st - 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fairfield, Md.

PARENTS

10 NAME OF FATHER Michael Gleason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Welch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Owen Thomas Husband 402 Carroll St.

15 Filed JUN 13 1922 19 Registrar Robert F. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 4th, 1923, to June 12th, 1923, that I last saw h[illegible] alive on June 3rd, 1923, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary and laryngeal

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Same

3. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? same.

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Robert W Johnson, M. D.

, 19 (Address) Brooklyn Bk Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Holy Cross June 15 1923

20 UNDERTAKER — ADDRESS

George L. Schwartz 4101 Buck Ave.

mation should be furnished, so that it may be properly classified. Fill all blanks.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Fill all blanks.
TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76679

CERTIFICATE OF DEATH.

167-001 D76679

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 Columbia ave ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jews Mirkowski

(a) RESIDENCE NO. 615 Columbia ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lost Knows ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Lost Knows

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Artist
(b) General nature of industry, business, or establishment in which employed (or employer) 601
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Stanislaus Mirkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mikkowna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Wm Cook
(Address) 522 E. North ave

15 Filed ..... 192 .....
Registrar

N 1 3 1922

Robert F. Harrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 - 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inhalation of Illuminating Gas

(duration) yrs. a few hours mos. ds.

CONTRIBUTORY (Secondary) Suicide

(duration) yrs. mos. ds.

(Signed) T. & K. Grumbine, M. D. (Coroner.)

6-13, 1923 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	June 14 1923
20 UNDERTAKER	ADDRESS
William Cook	522 E North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76680

D76680

CERTIFICATE OF DEATH.

100-001

4

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 772 W. Lanvale ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Mason

(a) RESIDENCE NO. 772 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Mason

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
68	-	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Prince Georges Co. Md.

PARENTS

10 NAME OF FATHER Edward Briscoe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co. Md

12 MAIDEN NAME OF MOTHER Emma Briscoe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charles Co Md

14 Informant (Address) Daniel Easton 916 E. Lanvale

15 Filed JUN 13 1923, 19 Robert P. Harrison; Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/11/1923

17 I HEREBY CERTIFY, That I attended deceased from 6/10, 1923 to 6/11, 1923,

that I last saw h-er alive on 6/10, 1923,

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. L. Cochran M. D.

6/4, 1923 Address) 772 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Market St Marys Co

DATE OF BURIAL 6-14 1923

20 UNDERTAKER David Easton

ADDRESS 916 E Lanvale

mation should be carefully supplied. Exact statement of ... may be properly classified. ... CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back of certificates.

FILM

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76681

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76681

CERTIFICATE OF DEATH.

114

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1307 (Street) Myrtle ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ottilie Goepper

(a) RESIDENCE. No. 1307 Myrtle Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if of foreign birth? 77 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Christian Goepper

6 DATE OF BIRTH (month, day, and year) 1824

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	95			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Gotfried Ernst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant John J. Goepper
(Address) 1307 Myrtle Av

15 Received JUN 13 1922, 19

Robert F. Harrison,
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1922

17 I HEREBY CERTIFY That I attended deceased from June 6 1922, to June 11 1922, that I last saw h er alive on June 10 1922, and that death occurred, on the date stated above, at 1030 P m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James K. Hooper, M. D.

6/14, 1922 (Address) 346 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	6-14-1922
20 UNDERTAKER	ADDRESS 916
Daniel Easton	Ga ay

mation should be carefully supplied. Also, see that it may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76682

CERTIFICATE OF DEATH.

111-001 D76682

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 681 W. Mulberry ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. Nicholson

1a) RESIDENCE NO. 829 Sarah Ann ST., — WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wesley Nicholson

6 DATE OF BIRTH (month, day, and year) April 10th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	75	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Evangelist

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Benjamin Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Caroline Proctor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Maggie Christy (Address) Research Church

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1923, to June 12, 1923, that I last saw her alive on June 10th, 1923, and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows:

Gastritis (duration) — yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) Gastro Enteritis (duration) — yrs 1 mos. — ds.

18 Where was disease contracted if not at place of death? 829 Sarah Ann St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edward Dallas Reagan M. D.

19 (Address) 133 E North St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 6/14 1923

20 UNDERTAKER James M. Kinner

ADDRESS 1020 E. Mad St

JUN 13 1923

Robert F. Harrison,

Registrar

Information should be carefully supplied. Exact statement of facts may be properly classified. Note CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D76683

CERTIFICATE OF DEATH

129 D76683

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 138 Caton Ave ST.; WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Ready

(Residence in Baltimore: No. 138 Caton Ave St.; 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: March 1, 188 (Month) (Day) (Year)

7 AGE: 40 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer): 121

9 BIRTHPLACE (State or country): Balto

PARENTS

10 NAME OF FATHER: Bill Ready

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Cooper

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bertha Washington

(Address) 138 Caton Ave

15 Filed ..... 191 ..... Robert P. Harrison, REGISTRAR

JUN 12 1922 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June 11, 191 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 191 . to. June 11 191 .
that I saw h alive on June 11 , 191 .
and that death occurred, on the date stated above, at 12.20 p.m.
The CAUSE OF DEATH* was as follows:

Edema of Glottis & Lung
Uremia

(Duration) 1 yrs. mos. 3 ds

Contributory (SECONDARY) Chronic Nephritis

(Duration) yrs. mos. ds.

(Signed) M. D.

June 11, 191 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Lebanon | DATE OF BURIAL: June 14 1922

20 UNDERTAKER: Samuel Densky | ADDRESS: Eddie

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76684 ✓ D76684

CERTIFICATE OF DEATH. — 23

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 5 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert James

(a) RESIDENCE NO. Unknown [illegible] WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie James

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Eastern Shore, Md.

PARENTS

10 NAME OF FATHER John James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Municipal Hospital Records.

(Address)

15 Filed JUN 13 1922 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1923

17

I HEREBY CERTIFY, That I attended deceased from February 21, 1923 to June 10, 1923.

that I last saw him alive on June 10, 1923.

and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Epidemic Encephalitis

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Terminal) (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. M. Powell, M. D.

6-11-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 6/14/23

20 UNDERTAKER Samuel Hendley

ADDRESS 1728 Eddlelt

mation should be carefully supplied. Exact statements may be properly classified. CAUSE OF DEATH in plain terms, so that it may be understood. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76685

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76685

CERTIFICATE OF DEATH.

X 46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. ~~Adam~~ Emma Miller.

(a) RESIDENCE NO. East Berlin Pa. ST., WARD East Berlin, Pa.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	Married.

5a If married, widowed, or divorced (or) WIFE of Adam C. Miller.

6 DATE OF BIRTH (month, day, and year) Oct. 11, 1876.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania.

PARENTS

10 NAME OF FATHER Andrew Spangler.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Alice Buff.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania.

14 Informant Andrew Miller (Address) East Berlin Pa

15 Filed JN 13 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1923

17

I HEREBY CERTIFY, That I attended deceased from April 13, 1923, to June 13, 1923, that I last saw her alive on June 13, 1923, and that death occurred, on the date stated above, at 10.40 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the uterus, with extension throughout the pelvis.

(duration) 0 yrs. 14 mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure.

(duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death? East Berlin, Pa.

Did an operation precede death? Yes Date of May 31, 1923.

Was there an autopsy? No.

What test confirmed diagnosis? Operation - exploratory

(Signed) J. W. Finney, M. D.

June 13 1923 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
East Berlin Pa	June 13 1923
20 UNDERTAKER	ADDRESS
Chenoweth & Son	Chestnut Ave

mation should be carefully supplied. Exact statement of facts CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76686 ✓ D76686

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Lewis

(a) RESIDENCE NO. 2251 Wilkins Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-13-23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 10 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Agnes Hospital Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Adam Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Lydia E Ellis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Joseph Adam Lewis (Address) 2251 Wilkins

Filed JUN 13 1922, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1923

17 I HEREBY CERTIFY, That I attended deceased from 6-13, 1923, to 6-13, 1923, that I last saw him alive on 6-13, 1923, and that death occurred, on the date stated above, at 10:25 a.m.

The CAUSE OF DEATH* was as follows:

Suffering of respiratory centers

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Prolonged labor

(duration) yrs. mos. ds.

Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Henry Steinmeller, M. D.

6/13, 1923 (Address) 327 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hanfield — DATE OF BURIAL June 14 1923

20 UNDERTAKER Eshenour & Son — ADDRESS Chestnut

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76687

CERTIFICATE OF DEATH.

31 D76687

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 S. Magnolia ave Hamilton ST., 27 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward A. Tierney

(a) RESIDENCE NO. 1 S. Magnolia ave ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 5. 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Soldier (Private)

(b) General nature of industry, business, or establishment in which employed (or employer) U. S. A.

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George J. Tierney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Freburger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant George J. Tierney (Address) Hamilton

15 JUN 14 1922 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1923

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1923, to June 11, 1923, that I last saw him alive on June 11, 1923, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R. C. H. Campbell M. D.

Jun 13, 1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	June 14 1923
20 UNDERTAKER Margaret H. Flynn	ADDRESS 1422 Light

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76688

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

145-003 D76688

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 214 S Hugh St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carmela Pieccirilli

(a) Residence No. 214 S Hugh St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Charles Pieccirilli

6-DATE OF BIRTH (month, day and year) August 2 1898

7-AGE, 24 yrs. 10 mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Italy

PARENTS.

10-NAME OF FATHER. Michael Papa

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Italy

12-MAIDEN NAME OF MOTHER. Theresa Demitti

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Italy

14- (Informant) Edwards Pieccirilli

(Address) 214 S Hugh

15- ROBERT N. KRAUTER Registrar.

JUN 14 1922

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 12 1923

17- I HEREBY CERTIFY, That I attended deceased from June 9, 1923 to June 12, 1923.

that I last saw h.. alive on June 12, 1923

and that death occurred, on the date stated above, at 12:50 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

2

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

E. L. Cassagne M. D.

(Signed)

6.13. 1923 (Address) 2en Hilton.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Vincent	June 15. 1923
20-UNDERTAKER.	ADDRESS
Wendell Appleton	37 S Sharp

Shall be carefully filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificate.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Child Birth 21 days ago

Premature

Spec.—1-10-21—M&T—1500 Rks.

D76689 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 D76689

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 526 w.west ST. 22 WARD)

2-FULL NAME Rosa Kirby

(a) RESIDENCE NO. 526 W.West ST., 22 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer Mrs Helen Mullen

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Andrew Ballard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Keysey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ella Gottinger

(Address) 928 Penna Ave

15 Filed JUN 14 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/13/1923

17 I HEREBY CERTIFY, That I attended deceased from 2/16/1923 to 6/12/1923 that I last saw her alive on 6/12/1923 and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Chronic (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Gundry Bowley M. D.

6/13/1923 (Address) 908 Shoppee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Ct

DATE OF BURIAL June 15 1923

20 UNDERTAKER C. D. Brown & Son

ADDRESS

Burial Permit Clerk

mation should be carefully supplied. Exact statement of decease may be properly classified. CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76690 HEALTH DEPARTMENT—CITY OF BALTIMORE 146 D76690

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3549 Cedar Ave ST., 13 WARD)

2-FULL NAME Althea L. Edwards

(a) RESIDENCE NO. 3549 Cedar Ave ST., 13 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William E. Edwards

6 DATE OF BIRTH (month, day, and year) June 8-1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20	—	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John M. White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Maryland

12 MAIDEN NAME OF MOTHER Adelaide V. Ashby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Maryland

14 Informant John M. White
(Address) 3549 Cedar Ave

JUN 14 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1923, to June 12 1923.
that I last saw h[illegible] alive on June 12, 1923,
and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:
Puerperal Septicemia
OK Corner.
F. J. Morrison

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Peritonitis - Broncho Pneumonia
(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? 3549 Cedar Ave

Did an operation precede death? Yes Date of May 23, 23

Was there an autopsy? No

What test confirmed diagnosis? Breath Heart-Eye + Heart Beat

(Signed) Herbert M. Foster, M. D.

, 19 (Address) 44 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's (Hampden) DATE OF BURIAL June 14 1923

20 UNDERTAKER Horace G. Burgee ADDRESS 663 Falls Rd

mation should be carefully supplied. Exact statement of OCCUPA-
that it may be properly classified.
CAUSE OF DEATH in plain terms, so that i
TION is very important. See instructions o

Spec.—1-16-21—M&T—1500 Bks.

D76691

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D76691

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. E Monument ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Rosenfeld :

(a) RESIDENCE NO. 1804 E. Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. 1 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailoring

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

150

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Moses Rosenfeld

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Bessie Taigor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant S. Rosenfeld

(Address) 1804 E Madison st

15 Filed JUN 14 1922 ROBERT R. REAL Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1923

17

I HEREBY CERTIFY, That I attended deceased from May 31, 1923, to June 13, 1923, that I last saw him alive on June 13, 1923, and that death occurred, on the date stated above, at 1.00 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) 1 yrs. 1 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Ernest S Edlavitch, M. D.

6-13, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	6/14 1923
20 UNDERTAKER	ADDRESS 427 E Balto St
M. Levinson & Son	

NOTE—AGE should be carefully supplied. Information should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Mitral Stenosis

no other history

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

162 D76692

CERTIFICATE OF DEATH.

D76692

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 201 Furrow ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl O'Brien

(a) RESIDENCE No. 201 Furrow ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 11th 1923

7 AGE Years Months Days: 1 If LESS than 1 day 20 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph J. O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Fitzgibbon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mother

(Address)

Filed JUN 14 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

87

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1923

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1923, to June 13, 1923, that I last saw h/ alive on June 13, 1923 and that death occurred, on the date stated above, at 3.40 P m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) J. Norwood Wilson M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health.

JUN 13 1923

N. B. Information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

N 76693

CERTIFICATE OF DEATH.

124 D76693

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Maggie Suese

(a) RESIDENCE NO. 741 W. Lexington ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	52	00		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitress 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. City Public Schools.

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John O'Neill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER ..... O'Day

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs O Kiak

(Address) 509 N Lexington

Filed JUN 14 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1923

17

I HEREBY CERTIFY, That I attended deceased from May 31, 1923, to June 12, 1923,

that I last saw her alive on June 12, 1923,

and that death occurred, on the date stated above, at 6-20 A m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis
pneumonia - Influenza
(Ad. W. Fuller, Jan.

(duration) 4 yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Acute Pneumonia, Edema.

(duration) ..... yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) Wm. J. Fuller M. D.

, 19 (Address) Univ. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	June 14 1923
20 UNDERTAKER W. M. Rouzer	ADDRESS 230 N Green

mation should be carefully supplied. Exact statement of ... CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Zygmunt)

D76694 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D76694

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 320 S Durham St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Frances Zygmunt

(a) Residence No. 320 S Durham St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) ~~x~~

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 19/22

7-AGE. ..... yrs. 8 mos. 25 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. none

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. John Zygmunt

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Martha Wolska

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Poland

14- (Informant) John Zygmunt

(Address) 320 S Durham St.

JUN 14 1922 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 13/23

17- I HEREBY CERTIFY, That I attended deceased from June 9th 1923 to June 13 1923.

That I last saw her alive on June 12 1923

and that death occurred, on the date stated above, at 4.45 A m

The CAUSE OF DEATH* was as follows

Bronchial Pneumonia

(Duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) /

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Rebberger M. D

19 (Address) 1709 Aliceanna

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary — DATE OF BURIAL. June 14 1923

20-UNDERTAKER. John M Welch — ADDRESS 803 Bank St

Should be carefully filled in, so that it may be properly classified. Exact statement of occupations is required. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76695 D76695

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. 4908 School Road St. Lowville Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine M. Wagner

(a) Residence No. 4908 School Road St. Lowville Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) June 7th 1868

7-AGE, 55 yrs. — mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Maryland

PARENTS.
10-NAME OF FATHER Conrad Wagner
11-BIRTHPLACE OF FATHER (city or town) (State or Country) Germany
12-MAIDEN NAME OF MOTHER Dorathea Becker
13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14-INFORMANT (Address) Primus Wagner 4908 School Rd Lowville

15-FILED JUN 14 1922 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 12, 1923

17-I HEREBY CERTIFY, That I attended deceased from Jan 20, 1915 to June 12, 1923, that I last saw h alive on May 24, 1923, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) (Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Bacillus in Sputum Physician

(Signed) John [illegible] M. D.

June 14 1923 (Address) 9365 Harford

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL, June 16 1923

20-UNDERTAKER Forest Lawn Funeral Home ADDRESS Fallston

Exact statement of OCCUPATION is necessary. Use words in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76696

CERTIFICATE OF DEATH.

31 D76696

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2603 E Oliver ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Francis Schammel

(a) RESIDENCE NO. 2603 E Oliver ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Schammel

6 DATE OF BIRTH (month, day, and year) Aug. 27. 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.
	40	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer) Otis Elevator Co.

(c) Name of employer Otis Elevator Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John F. Schammel. Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Elizabeth Mull

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) August F Schammel 2437 Edmund St

Filed JUN 14 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1921, to June 13, 1923,

that I last saw him alive on June 12, 1923

and that death occurred, on the date stated above, at 4 30 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonary Tuberculosis

(duration) 1 yrs. 6 mos 13 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Thos. F. Stevens, M. D.

6/13, 1923 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem DATE OF BURIAL 6/16 1923

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76697

161-001 D76697

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3739 Gough St., 76 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Bauernfeind

(a) RESIDENCE NO. 3739 Gough ST. 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 13 1923

7 AGE — Years — Months — Days — If LESS than 1 day 12 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Bauernfeind

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Catherine Hoeun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Catherine Bauernfeind
(Address) 3739 Gough St

15 Filed JUN 14 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1923

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1923, to June 14, 1923, that I last saw h-e alive on June 13, 1923 and that death occurred, on the date stated above, at 5-15a m.

The CAUSE OF DEATH* was as follows:

6 Month Foetus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace P. Tilson M. D.

6/17, 1923 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 6/14 1923

20 UNDERTAKER Philip Hennig — ADDRESS 2016 Orleans

N.B. Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. DEATH is very important.

Spec.—1-10-21—M&T—1500 Bks.

(Jurgensen)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76698 D76698

CERTIFICATE OF DEATH

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2634 E. Balto. ST., 6 WARD)

2-FULL NAME Peter Jurgensen

(a) RESIDENCE NO. 2634 E Balto ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 6 Ky. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Jurgensen,

6 DATE OF BIRTH (month, day, and year) May 29. 1846.

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	77 yrs.		15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packing agent

(b) General nature of industry, business, or establishment in which employed (or employer) Steamship

(c) Name of employer Schumacher & Co.

9 BIRTHPLACE (city or town) (State or country) Flensburg Denmark

PARENTS

10 NAME OF FATHER Nicolaus Jurgensen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark

12 MAIDEN NAME OF MOTHER Augusta Hansen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denmark

14 Informant Mrs. Agnes King

(Address) 22 N. Ingleside Ave.

15 Filed JUN 14 1923, 19 Robert P. HARRISON, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 1st. 1923. to June 12 1923.

that I last saw him alive on June 12 1923.

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

Dyspnea

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

duration 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of May 1 1923.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. H. Meyer Jr. M. D.

6/13. 1923 (Address) 1638 E Balto. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem.

DATE OF BURIAL: 6/15/1923

20 UNDERTAKER: J. A. Moran

ADDRESS 3000 E Baltoh.

mation should be carefully supplied. Exact statement of ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Ballistrieri)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76699

CERTIFICATE OF DEATH.

111-001 D76699

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hosp. ST., 10 WARD)

2-FULL NAME Josie Ballistrieri

(a) RESIDENCE NO. 926 Ashland Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Mr. Santo Ballistrieri

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Marious Colori

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Maria Chaviere

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Carmela Ballistrieri

(Address) 926 Ashland ave

15 Filed JUN 14 1923, 19 Robert F. Harrison, Registrar

(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 23

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1923, to June 13, 1923, that I last saw her alive on June 13, 1923, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) (Ulcer of Stomach (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of June 11, 1923

Was there an autopsy? No.

What test confirmed diagnosis? Operation.

(Signed) Frank C. Morris, M. D.

(Address) 1300 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	6/15 1923
20 UNDERTAKER George J. Ruth	ADDRESS 1735 Harford Ave

mation should be carefully supplied. Exact statement of the CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

D76700

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7 D76700

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 Calvert av ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George R Powell Jr

(Residence in Baltimore: No. 1813 Calvert av St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, May 7, 1917
(Month) (Day) (Year)

7-AGE, ...yrs. 3 mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, George R Powell

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Mary E Jules

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George R. Powell

(Address) 1813 N. Calvert

15-

Filed ..... Robert P. Harrison, ...
Registrar.

JUN 14 1922

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 14, 1922
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 13 1922, to June 14 1922, that I saw h[illegible] alive on June 14 1922, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Convulsions

6 hours
(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Measles ?

4
(Duration) ....yrs. ....mos. .... ds.

(Signed) Chas R Evans M. D.

June 14, 1922. (Address) 2108 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Ballo. Cem. DATE OF BURIAL, June 15, 1922

20-UNDERTAKER J. J. Burns & Son ADDRESS 1564 Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76701 45 D76701

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hosp. Monument & Rutland REGISTERED NO.

CITY OF BALTIMORE: (NO. 9 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar Nadditch

(a) RESIDENCE NO. 1305 Ensor ST, WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M | 4 COLOR OR RACE: H. | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Nadditch

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	6	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

050

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis
(Address) 1439 E Balto St

15 Filed JUN 14 1923 Robert P. Harrison, Registrar
By Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1923

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1923 to June 13th 1923.
that I last saw h[illegible] alive on June 13th 1923
and that death occurred, on the date stated above, at 2.45 P m.
The CAUSE OF DEATH* was as follows:
Myocardial Failure

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Carcinoma & Metastases, January in Colon (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? Yes By Laboratory & Pathologist
What test confirmed diagnosis?
(Signed) A. Adler, Pathologist M. D.
6/13 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	June 15 1923

20 UNDERTAKER: Jack Lewis ADDRESS: 1439 E Balto St

N. B.—WRITE plainly. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificate.

D76702

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76702

CERTIFICATE OF DEATH.

118-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Hebrew Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Israel Butcher

(Residence in Baltimore: No. 218 N. Front St.; 25 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widow(er), or Divorced. (Write the word.) Wid

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1..... (Year)

7-AGE. 80? yrs.....mos.....ds. If LESS than 1 day, ...hrs. or....mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Butcher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Meyer Butcher

11-BIRTHPLACE OF FATHER. (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Rose Goldstein

13-BIRTHPLACE OF MOTHER. (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Son-in-law

(Informant) Jacob Brickman

(Address) 218 N. Front St

15-

Filed 2 192

Robert F. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 14 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock - following operations for strangulated Hernia (Right)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) J. S. T. Dalton M. D.
(Coroner)

6/14 1923 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Hebrew Rosedale DATE OF BURIAL, June 16 1923

20-UNDERTAKER. Jack Lewis ADDRESS 1439 E. Baltimore

N. B.—Every question must be answered, and if any part is unknown, or does not apply, a dash (—) must be written. Do not state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificate.

JUN 14 1923

76703

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76703 CERTIFICATE OF DEATH. X | 88 D76703

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Deaf Hos. St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Keeper

(Residence in Baltimore: No. Rocks - Md St.; yrs. mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, Unknown
(Month) (Day) (Year)

7-AGE. 50 about yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) 18

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Wm. Keeper

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. W. Holden

(Address) Delta Pa

15- JUN 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 14 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Concussion (accidental)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fell off horse

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

June 14, 1923 (Address) 1 D Frederick Co

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? Rocks, Md.

Former or usual residence Rocks, Md.

19-PLACE OF BURIAL OR REMOVAL, Rocks-Md DATE OF BURIAL. June 16 1923

20-UNDERTAKER, Wm J Nicholson ADDRESS Norrisville Pa

N. B.—Every item of information must be given in plain terms, so that it may be properly classified. Exact statements of occupation, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of occupation, is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D76704

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1923 D76704

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 S. High St. ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Culotta

(a) RESIDENCE NO. 102 S. High ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced (or) WIFE of Guiseppe Culotta

6 DATE OF BIRTH (month, day, and year) — 1863

7 AGE 59 Years Months Days If LESS than 1 day, ...hrs. or..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Antonio Lubiano Sic

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Concetta Guglielmo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Giuseppe Culotta

(Address) 102 S. High st.

15 JUN 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-13-1923

17 I HEREBY CERTIFY, That I attended deceased from 6-5- 1923 to 6-13 1923

that I last saw h[illegible] alive on 6-13 1923

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Fracture lower end of rt femur & other bruises as result of [redacted] fall

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical -

(Signed) J. D. Suggs M. D.

6/14/23 (Address) 1507 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 6/15/1923

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Harford

NOTE—mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76705

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

102. D76705

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 E. 23d st St. 12 WARD)

2-FULL NAME Annie Burrell

(a) RESIDENCE. No. 216 E. 23d st ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	Col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife of Scott Burrell

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0'0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co Md

PARENTS

10 NAME OF FATHER Thomas Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent Co Md

12 MAIDEN NAME OF MOTHER Laura Cotton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co Md

14 Informant Mrs. Lillian H. Lewis (Address) 173 Wyman st

15 Filed JUN 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1923

17 I HEREBY CERTIFY, That I attended deceased from May 28 1923, to June 17 1923

that I last saw her alive on June 17 1923

and that death occurred, on the date stated above, at 1130 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure Sudden

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pleurisy 19 days

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. A. Richardson, M. D.

June 17, 1923 (Address) 112 W. 25th st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetery	June 15 1923

20 UNDERTAKER	ADDRESS
Joseph a Farrell	2319 Pine

mation should be entered. Any [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76706

CERTIFICATE OF DEATH.

90 D76706

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 Madison Ave ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emile A. Runge

(a) RESIDENCE NO. 1512 Madison Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? About 60 yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maria L. Runge (nee Green)

6 DATE OF BIRTH (month, day, and year) June 6, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Cigar Mfgr.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER ------ Runge

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Augustus A. Runge

(Address) 1512 Madison Ave.

15 Filed JUN 15 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1923

17 I HEREBY CERTIFY, That I attended deceased from May 9 , 1923 , to June 13 , 1923 ,

that I last saw him alive on June 12 , 1923 ,

and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Mitral - Regurgitation

(duration) yrs. 1 mos. 4 ds.

CONTRIBUTORY (Secondary) Passive Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry Boyd M. D.

, 19 (Address) 602 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL June 15 1923

UNDERTAKER Harry H. Witzke — ADDRESS 1532 W Lombard

mation should be carefully supplied. Age CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—1-10-21 M&T 1500 Blks.

2D76707

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76707

CERTIFICATE OF DEATH.

96

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John T. LeGates

(a) RESIDENCE NO. 612 E. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or countrr) Maryland.

PARENTS

10 NAME OF FATHER Mitchell LeGates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Willie Child

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Hospital Records (Address)

15 JUN 15 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1923

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1923, to June 12, 1923.

That I last saw him alive on June 12, 1923.

and that death occurred, on the date stated above, at 6-15 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Arterio Sclerosis

Aortic Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. J. Sutton, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL June 15 1923

20 UNDERTAKER Mrs. Albert E. Fuller ADDRESS Harford Ave.

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76708

CERTIFICATE OF DEATH.

44 D76708

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3826 Foster Ave St. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Fishburn

(a) RESIDENCE No. 3826 Foster Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Fishburn

6 DATE OF BIRTH (month, day, and year) October 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	75	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Morrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Minnie Bombardt

(Address) 3826 Foster Ave

15 JUN 15 1923

16 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1923

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1923, to June 14, 1923, that I last saw h alive on June 14, 1923 and that death occurred, on the date stated above, at 3 15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 11-6 mos — ds.

CONTRIBUTORY (Secondary) Toxemia (Uremia)

(duration) yrs. 6 wks ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) Thos O'Donnell, M. D.

, 19 (Address) 125 N Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Paul's Cemetery	June 16 1923

20 UNDERTAKER ADDRESS

H Vander & Sons 1710 Eutaw

N. B.—Information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D76709

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76709

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3 So. 6 st ST., Brooklyn WARD)

REGISTERED NO. 109-802

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen A Gast

(a) RESIDENCE NO. 3 So 6 st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) April 13 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	1	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 87 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Shackelford + Co

9 BIRTHPLACE (city or town) (State or country) Brooklyn Md

PARENTS

10 NAME OF FATHER Conrad M Gast

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa B Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Address) Conrad M Gast 3 South 6 st st Brooklyn

15 Filed JUN 15 1923, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1923

17 I HEREBY CERTIFY That I attended deceased from May 24, 1923, to June 14, 1923, that I last saw h[illegible] alive on June 13, 1923, and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

1. LaGrippe

(duration) 2 yrs. 21 mos. ds.

CONTRIBUTORY (Secondary) Infected Tonsils

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No, Date of —

Was there an autopsy? No

What test confirmed diagnosis? Suspicion

(Signed) [illegible] M. D.

, 19 (Address) 1340 Chestnut

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery DATE OF BURIAL June 16 1923

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D76710 — 129 — D76710

D76710 — REGISTERED No. C

1. PLACE OF DEATH

CITY OF BALTIMORE (No. 309 Warren Ave. St. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2. FULL NAME Richard Dwight Lyman

(Residence in Baltimore: No. 309 Warren Ave. St.: 57 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: November (Month) 21 (Day), 1863 (Year)

7. AGE: 59 yrs. 6 mos. 24 ds. If LESS than 1 day, ... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): City Employee

9. BIRTHPLACE (State or country): New York

PARENTS

10. NAME OF FATHER: Orville D.Lyman

11. BIRTHPLACE OF FATHER (State or country): New York

12. MAIDEN NAME OF MOTHER: Joanna Gallion

13. BIRTHPLACE OF MOTHER (State or country): Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sallie E.Lyman (Wife)
(Address) 309 Warren Ave.

15. JUN 15 1923 — ROBERT R. KNAUER, Burial Permit Clerk — REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 14 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 6, 1923, to, Jun 14 1923, that I saw h alive on Jun 14, 1923, and that death occurred, on the date stated above, at 6.45 m.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Indefinite (Duration) yrs. mos. ds

Rheumatism

Contributory (SECONDARY) (Duration) yrs. mos. 2 ds.

(Signed) R. C. L. Campbell M. D.

Jun 15, 1923 (Address) 1424 Hanover

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18. LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mount Olivet Cemetery — DATE OF BURIAL: June 16, 1923

20. UNDERTAKER: John F Denny — ADDRESS: 715 Light St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76711

CERTIFICATE OF DEATH.

129 D76711

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 43 E. Henrietta ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME albert McClean

(a) RESIDENCE No. 43 E. Henrietta ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Anna L McClean

6 DATE OF BIRTH (month, day, and year) Mar 15 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	3	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): Iron & Steel

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER Robert McClean

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Margaret Hotchman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Anna L. McClean (wife)

(Address) 43 E Henrietta St

15 Filed JUN 15 1922 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6. 14. 23 19

17 I HEREBY CERTIFY, That I attended deceased from 4. 10. 23 19 to 6. 14. 23 19, that I last saw him alive on 6. 13. 23 19, and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Cardiac Hypertension

Myocarditis 1 yrs 1 mos ds. (duration)

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

Acute Edema of the Lungs (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Laboratory findings

(Signed) J. Edward Norris, M. D.

6-14-23 19 (Address) 1435 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	June 16 19 23
20 UNDERTAKER	ADDRESS
John F Denny	715 Light St

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76712

D76712

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE (No. Bay View St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Kidwell

(Residence in Baltimore: No. 1217 E. Oliver St.; 34 yrs., ... mos., ... ds.)

N. B.—Every item of information should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Apr 18th 1857
(Month) (Day) (Year)

7-AGE. 66 yrs. 1 mos. 25 ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Electrician
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Washington D.C.

PARENTS.

10-NAME OF FATHER. Geo. W. Kidwell

11-BIRTHPLACE OF FATHER, (State or Country). Prince George Co. Md

12-MAIDEN NAME OF MOTHER. Rebecca Lynch

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Sadie A. Kidwell

(Address) 1217 E. Oliver St

15-Filed JUN 15 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 13th 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and (autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock

(Duration) 6 hours

CONTRIBUTORY (Secondary) Fell 75 ft - 3 ribs on each side fractured

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Hoffman M. D. Coroner

(Address) Curtis Bay, Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cemetery DATE OF BURIAL. June 16 1923

20-UNDERTAKER. Henry Hoeck Son ADDRESS 130 E Eager St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76713

CERTIFICATE OF DEATH.

45 ✓ D76713

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 807 N. Central Ave WARD 10)

2-FULL NAME Margaret A. Roesinger

(a) RESIDENCE NO. 807 N. Central Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of John Roesinger

6 DATE OF BIRTH (month, day, and year) Aug 3-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Dietrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Teresa Schmeraff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant John Roesinger

(Address) 807 N. Central Ave

15 JUN 15 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1923

17 I HEREBY CERTIFY, That I attended deceased from April, 1923, to June 13, 1923, that I last saw h— alive on June 13, 1923; and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Corpus

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Toxemia of Pregnancy

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Contemporanch, M. D.

June 14 1923 Address) 817 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. DATE OF BURIAL June 15 1923

20 UNDERTAKER Frank A. Fink ADDRESS 915 N. Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Pks.

D76714

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D76714

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 Park Ave ST. 14 WARD)

2-FULL NAME Emma L. Taylor

(a) RESIDENCE. NO. 1615 Park Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jonathan K Taylor

6 DATE OF BIRTH (month, day, and year) July 24/1842

7 AGE Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
80	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10 NAME OF FATHER Joseph Pyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.

12 MAIDEN NAME OF MOTHER Mary Cloud

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del.

14 Informant Jessie A Phipps
(Address) 1615 Park Ave.

15 Filed JUN 15 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1923

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1923, to June 13, 1923, that I last saw h alive on June 12, 1923, and that death occurred, on the date stated above, at 5.20. A m.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia ORW

(duration) yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Fracture left femur

(duration) 1 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jane C. Clarke M. D.

(Address) Latrobe Apt. Charlesmont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Friends Burial Ground	June 15 1923

20 UNDERTAKER ADDRESS

Chas. E. Franck 822 Madison Ave

mation should be carefully supplied. Arc
CAUSE OF DEATH in plain terms, so that it ma
TION is very important. See instructions on ba

AK S

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accident - Fell in Bath Room

Spec.—1-10-21—M&T—1500 Rks.

D76715 HEALTH DEPARTMENT—CITY OF BALTIMORE D76715

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 N. Bradford St. ST., 6 WARD)

REGISTERED NO. 4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris Hauer. (Chase)

(a) RESIDENCE NO. 8 N. Bradford St. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16 - 1922

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto.
(State or country) md.

PARENTS

10 NAME OF FATHER Charles Hauer

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) md.

12 MAIDEN NAME OF MOTHER Hilda Lotz.

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) md.

14 Informant Charles Lotz.
(Address) 8 N. Bradford St.

15 JUN 15 1922 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1923

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1923, to June 14, 1923, that I last saw h[illegible] alive on June 13, 1923, and that death occurred, on the date stated above, at 5.40 a. m.

The CAUSE OF DEATH* was as follows:

W Coopings Cough

..... (duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) E. L. Parsons, M. D.

June 14, 1923. (Address) Ten Hills.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	June 15 1923.
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe St.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. Particulars of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D76716

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76716

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 3417 Claremont St., 26 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Horsch

(Residence in Baltimore: No. 3417 Claremont St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. Jan (Month) 6th (Day) 1846 (Year)

7-AGE. 77 yrs. 6 mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Michael Vollmuth

11-BIRTHPLACE OF FATHER. (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Elizabeth Waeth

13-BIRTHPLACE OF MOTHER. (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Shuesser

(Address) Essex Md

15- Filed JUN 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 14 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

Coroner

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton M. D.

June 14th 1923. (Address) Curtis Bay Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cem.	June 16 1923
20-UNDERTAKER. Zeller Bro Zeller	ADDRESS 403 S. Wolfe St.

N. B.—Every item of information should be carefully supplied. ALL blanks must be filled. Do not abbreviate. Write plainly. Ditto marks may not be used. Do not leave any blanks. Be sure to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76717 HEALTH DEPARTMENT—CITY OF BALTIMORE D76717

86-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 666 Pabory ST.; 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Beverly

(a) RESIDENCE. No. 666 Pabory ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 9 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 1, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Linzy Beverly

11 BIRTHPLACE OF FATHER (city or town) Essex Co (State or country) Va.

12 MAIDEN NAME OF MOTHER Alice Blackston

13 BIRTHPLACE OF MOTHER (city or town) A. A. Co (State or country) Md.

14 Informant Alice Beverly (Address) 666 Pabory St

15 Filed JUN 15 1922 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1922

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1922, to June 11, 1922, that I last saw he alive on June 11, 1922, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Otitis Media

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Abscess

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) William A. Harris, M. D.

, 19 (Address) 1200 Penn. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cemetery DATE OF BURIAL June 15 1922

20 UNDERTAKER Edward Bryan ADDRESS 631 Orleans St

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76718 D76718

CERTIFICATE OF DEATH.

47

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1906 Orleans ST., 6 WARD)

2-FULL NAME Margaret Winterling

(a) RESIDENCE NO. 1906 Orleans ST., 6 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 2 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Christopher C. Winterling

6 DATE OF BIRTH (month, day, and year): Mar. 28 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Boerstein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Christopher C. Winterling

(Address) 1906 Orleans St.

JUN 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 13th 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1923, to June 13, 1923, that I last saw her alive on June 13, 1923, and that death occurred, on the date stated above, at 9.20 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma (adeno) of Left Mammary Gland—

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb. 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic Exam

(Signed) Francis M. Krause, M. D.

, 19 (Address) 3500 E. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL 6/16 1923

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans St

N. B. AGE should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76719

CERTIFICATE OF DEATH.

109-002

109. D76719

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 Riggs ave ST., 16 WARD)

2-FULL NAME James Henry Woods

(a) RESIDENCE NO. 1404 Riggs ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Singer

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 24th 1918

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) 4 yrs 6 mo
(State or country) Baltimore

PARENTS

10 NAME OF FATHER James Henry Woods

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mrs Susie Woodland
(Address) 1404 Riggs ave

15 Filed JUN 15 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1923

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1923, to June 14, 1923, that I last saw h alive on June 14, 1923, and that death occurred, on the date stated above, at 5:5 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Frank Saunders M. D.

6th, 1923 (Address) 1123 N. Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL June 16 1923

20 UNDERTAKER Sam'l W. Case Sons

ADDRESS Wm Mc

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. If unknown it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Acute Tonsilitis

Spec.—1-10-21—M&T—1500 Bks.

D76720

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D76720

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 N. Collington ST., 8 WARD)

2-FULL NAME Doris Adele Edelmeier

(a) RESIDENCE NO. 1817 N Collington ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 29 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	6	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Earl Edmeier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Nellie Wordmaster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Earl Edmeier (Address) 1817 N Collington Ave

15 Filed ..... 19 ..... Registrar

JUN 15 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1923

17 I HEREBY CERTIFY, That I attended deceased from June 6th 1923 to June 14 1923.

That I last saw h[illegible] alive on June 14 1923.

and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Diphtheria (duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Stitch Sympathetic Paralysis (duration) yrs. 7 mos ds.

18 Where was disease contracted if not at place of death? 1817- Collington Ave.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Culture

(Signed) Chas Jones M. D.

19 (Address) 2202 Ridgely

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 15 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E. Lafayette Ave.

ROBERT R. KRAUTER, Registrar

INFORMATION should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–1-10-21–M&T–1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76721

CERTIFICATE OF DEATH.

135 D76721

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 07 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Seitz

(a) RESIDENCE NO. 654 Portland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charlotte Seitz

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	89			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Seitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Niesel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Albert Seitz [illegible] Portland

15 JUN 15 1923 ROBERT R. KRANTZ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/14 1923

17 I HEREBY CERTIFY, That I attended deceased from 6/4 1923, to 6/14 1923, that I last saw him alive on 6/14 1923, and that death occurred, on the date stated above, at 9 15 p. m.

The CAUSE OF DEATH* was as follows:

Hypertrophied prostate

Generalized arteriosclerosis

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acutes urinary retention

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Milton E Lang, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 18, 1923
20 UNDERTAKER Philip Seward & Son	ADDRESS 1826 W North Ave

mation should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76722

D76722

CERTIFICATE OF DEATH.

129 ✓

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1921 Wood-Brook Ave St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thos. J. Richardson

(Residence in Baltimore: No. 2821 Woodbrook Ave St.; 3 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ..., 1862
(Month) (Day) (Year)

7-AGE, 61 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Conductor
(b) General nature of industry, business, or establishment in which employed (or employer) B&O R.R. Co

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, James Richardson

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Mary Jane Bunton

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Beulah Richardson

(Address) 2821 Woodbrook

15- JUN 15 1923 ROBERT R. KRANTER, Registrar.
Filed ....., 191... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 13, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct. 14 1922, to June 13 1923, that I saw him alive on June 13 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis &
Chronic Interstitial Nephritis
with arteriosclerosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Measles

(Duration) yrs. mos. 2 ds.

(Signed) J. T. Chesney M. D.

6/15, 1923 (Address) 804 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathedral — DATE OF BURIAL, June 16, 1923

20-UNDERTAKER M. Fahey & Son — ADDRESS 180 W. North

N. B.—Every item of information must be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76723 ✓ X38 D76723

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 733 School St. 15 WARD)

2-FULL NAME Mrs. Frances Parker

(a) RESIDENCE. NO. 733 School ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47 52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert County Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Thomas Parker
(Address) 733 School St.

15 Filed ..... 19..... Burial Permit Clerk.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13th 19 23

17 I HEREBY CERTIFY, That I attended deceased from May 16th, 19 23, to June 13th 19 23,
that I last saw h alive on June 13th, 19 23,
and that death occurred, on the date stated above, at 6:17 p. m.
The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Valvular Endocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) E. Bell M. D.

, 19 (Address) 1322 Bilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chapelgate Jas Calvert Co Md	June 15 1923

20 UNDERTAKER James N. Hearer

ADDRESS 558 Pratt

mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76724

CERTIFICATE OF DEATH.

74-001

74 D76724

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 N Lyson ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Thomas

(a) RESIDENCE No. 405 N Lyson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer Balto md

9 BIRTHPLACE (city or town) Don't Know
(State or country)

PARENTS

10 NAME OF FATHER Frank Jones

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Isabel Thomas

13 BIRTHPLACE OF MOTHER (city or town) Balto md
(State or country)

14 Informant Mrs. R. G. Elliott
(Address) 1725 Lakeland Ave

15 Filed ..... 192 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 12 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy~~ inquiry.) thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Don't Know (duration) ..... yrs. ..... mos. ..... ds.

(Signed) T T Bouch M. D. (Coroner.)

Jan 14 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL Jan 16 1923

ADDRESS

20 UNDERTAKER Mrs Robert F Elliott 1725 Lakeland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D76725

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76725

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gladys Newbell

(Residence in Baltimore: No. 1804 E. Madison St. St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
female	black	single

6-DATE OF BIRTH. June 4/23 1.....
(Month) (Day) (Year)

7-AGE. 2 yrs. mos. 8 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Stuart Newbell

11-BIRTHPLACE OF FATHER. (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Annie Newbell(corre

13-BIRTHPLACE OF MOTHER. (State or Country). Balto.&d.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stuart Newbell

(Address) 1804 E. Madison St.

JUN15 1923 Filed 192... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 12/23 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) autopsy find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lead-poisoning- accidental-
obtained from toys etc.
(Autopsy at hospital)

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) J. S. H. Cairns M. D.
(Coroner.)

6/15/23 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	June 15 1923
20-UNDERTAKER.	ADDRESS
Mrs H C Elliott	1725 Eutaw Ave.

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76726

CERTIFICATE OF DEATH.

100-00 D76726

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 915 S. Clinton St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank J. Koerner

(a) Residence No. 915 S. Clinton St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Sept. 22-1921

7-AGE.	If LESS than 1 day.
1 yrs. 8 mos. 23 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md

PARENTS.

10-NAME OF FATHER, Henry Koerner

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore, Md

12-MAIDEN NAME OF MOTHER, Gertrude Brown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore, Md

11- (Informant) Henry Koerner Sr.

(Address) 915 S. Clinton St.

13- JUN 15 1923 Filed ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 15 1923.

17- I HEREBY CERTIFY, That I attended deceased from June 7th. 1923 to June 15. 1923

that I last saw h[illegible] alive on June 14th. 1923

and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ... yrs. ... mos. 8 ... ds.

CONTRIBUTORY (Secondary) —

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. W. Jones M. D.

6/15/. 1923 (Address) 1011 N. Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Carmel Cemetery	June 16 1923
20-UNDERTAKER.	ADDRESS
Girkler + Girkler	1739 E. Cager St.

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76727 D76727

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 167-001 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1126 Lauren St. 15 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... George Brosius

(Residence in Baltimore. No. 1126 Laurens St. St.; yrs. 60 mos. 4 ds. 6)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	married

6-DATE OF BIRTH. Feb 7 1863
(Month) (Day) (Year)

7-AGE. 60 yrs. 4 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Butcher
(b) General nature of industry, business, or establishment in which employed (or employer)..... 013

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Jacob Brosius

11-BIRTHPLACE OF FATHER. (State or Country). France

12-MAIDEN NAME OF MOTHER. Louise Smith

13-BIRTHPLACE OF MOTHER. (State or Country). Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Mrs. Liz Brosius

(Address)..... 1126 Laurens St.

15- ROBERT R. KRAUTER,
Filed..... 1923 Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 13 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicid by Illuminating Gas.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

June 14 1923 (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL,
London Park Cem June 16 1923

20-UNDERTAKER, ADDRESS
Jos Loerdens Son 2178 Pa Ave

N. B.—Every item of information should be carefully supplied. Also, that it may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76728

CERTIFICATE OF DEATH.

D76728

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mercy Hospital St., 23 Ward)

2-FULL NAME Genevieve Meyer (MEYER)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1018 Light St. St., 13 Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) May 24, 1902

7-AGE. 21 yrs. 2 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Meyer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Fortunato

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Mrs. Meyer

(Address) 1018 Light St.

15-

Filed JUN 15 1923 [illegible] Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 14 '23

17- I HEREBY CERTIFY, That I attended deceased from May 26 1923 to June 14 1923 that I last saw h.. alive on June 14 1923 and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Streptococcic Meningitis

(Duration) ..... yrs. ..... mos. 21 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) ..... yrs. ..... mos. 2 ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Cyto Degree

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount DATE OF BURIAL. 6/15 1923

20-UNDERTAKER. J. H. Lakey & Sons ADDRESS 13 Light St

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—6-9-13—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D76729

D76729

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 5 Eastdale ST. 23 WARD)

2-FULL NAME Thomas McNally

(a) RESIDENCE. NO. 5 Eastdale ST. 23 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth McNally

6 DATE OF BIRTH (month, day, and year) May 1 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 662

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick McNally

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Mlch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs McNally (Address) 5 Eastdale

15 Filed JUN 15 1923 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 5, 1923, to June 13, 1923, that I last saw h im alive on June 13, 1923, and that death occurred, on the date stated above, at 2 30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Path.

(Signed) J Mulcahy, M. D.

6/13, 1923 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL 6/16 1923

20 UNDERTAKER J F Tobey Sons

ADDRESS 1318 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76730

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D76730

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 321 N Carey St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella F Pitcher (PITCHER)

(a) Residence No. 321 N Carey St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Wm L. Pitcher

6-DATE OF BIRTH (month, day and year) Aug 1 1857

7-AGE. Yrs. 75 mos. 10 ds. 13

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Md

PARENTS.

10-NAME OF FATHER Philip S Jackson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md

12-MAIDEN NAME OF MOTHER Amelia Owens

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md

14- (Informant) Wm L. Pitcher

(Address) 321 N Carey St

15- Filed ....., 192.... Robert P. Harrison, Registrar.

JUN 15 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 14 23

17- I HEREBY CERTIFY, That I attended deceased from Nov 10 (19 22) to June 14 (19 23)

that I last saw h.. alive on June 14 (19 23)

and that death occurred, on the date stated above, at 6 10 P m.

The CAUSE OF DEATH was as follows*:

Diabetis Mellitis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Kidney

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward A Morgan M. D.

, 19 (Address) 1327 Hunt Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park — DATE OF BURIAL. June 16 19 23

20-UNDERTAKER. Geo H Smith — ADDRESS 2000 W Baltimore

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76731

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hospital.

CITY OF BALTIMORE: (No. ..... ST., 18 WARD)

2-FULL NAME Baby Lemon.

(a) RESIDENCE NO. 2317 Hollins St., City ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) May 15, 1923

7 AGE — Years: ..... Months: ..... Days: 23 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Irene Lemon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant ..... (Address) Johns Hopkins Hospital

15 Filed JUN 15 1923, 19... Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1923

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1923, to June 7, 1923, that I last saw him alive on June 7, 1923, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) Life yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) A. H. Mesch, M. D.

..... 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Johns Hopkins Hospital

DATE OF BURIAL ..... 19...

20 UNDERTAKER .....

ADDRESS .....

JUN

JUN 15 1923

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mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76732

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5

161-00 D76732

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Santo Cainabuca

(Residence in Baltimore: No. 307 N. Exeter St. St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be given in YEARS. If less than one year, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	Single

6-DATE OF BIRTH. June 23 1.....
(Month) (Day) (Year)

7-AGE. ....yrs. ....mos. ....ds. If LESS than 1 day, 16 hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Chas. Cainabuca

11-BIRTHPLACE OF FATHER. (State or Country).

12-MAIDEN NAME OF MOTHER. Mary

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Hopkins Hospital

(Address)

15- Robert P. Harrison,

Filed ....192.... Burial Permit Clerk Registrar.

JUN 15 1923 0-172

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 11/23 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity- 7mons. gestation

(Autopsy at hospital)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. H. Cotter, M. D.
(Coroner)

6/13/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.... yrs.... mos.... ds. In the State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

20-UNDERTAKER. ADDRESS.

JOHNS HOPKINS HOSPITAL
Commissioner Health.

JUN 15 1923

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76733

CERTIFICATE OF DEATH.

161-00 D76733

1-PLACE OF DEATH

City of BALTIMORE: (No. 118 So Exeter St., 3 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Baby Barker

(a) Residence No. 118 So Exeter St

(Usual place of abode) St., Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. 10 days

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, W/wh

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Jan 14 - 23

7-AGE, ... yrs. ..... mos. ..... ds.

If LESS than 1 day, 20 hrs. or ..... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... Infant

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town)... Baltimore
(State or Country),

PARENTS.

10-NAME OF FATHER, Joseph Baker

11-BIRTHPLACE OF FATHER (city or town) Md
(State or Country),

12-MAIDEN NAME OF MOTHER Josephine Cisneros

13-BIRTHPLACE OF MOTHER (city or town)... Md
(State or Country),

14-

(Informant)...

(Address)...

15-

Filed ..... Robert P. Harrison
Registrar.

UN 15 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Jan 14, 23

17- I HEREBY CERTIFY, That I attended deceased from Jan 14, 1923 to Jan 14, 1923

that I last saw h[illegible] alive on Jan 15, 1923

and that death occurred, on the date stated above, at 9.10 P. m.

The CAUSE OF DEATH* was as follows:

Infn Marasmus
Congenital Malformation

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?...

Did an operation precede death?... Date of...

Was there an autopsy?...

What test confirmed diagnosis...

(Signed) Joseph L. Valentine M. D.

Jan 15, 1923 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPIT

DATE OF BURIAL, JUN ..... 19....

20-UNDERTAKER. ADDRESS

Should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. In filling out instructions on back of certificates.

Spec—12-23-21—E.S.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76734

CERTIFICATE OF DEATH.

D76734

1-PLACE OF DEATH

City of BALTIMORE: (No. 118 So Exeter St. 3 Ward)

Registered No. 161-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Barber

(a) Residence No. 118 So Exeter St. Ward

(Usual place of abode)

(If non-resident give city or town and state)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Twin Miscarriage

6-DATE OF BIRTH (month, day and year) June 14-23

7-AGE, ...yrs....mos....ds. If LESS than 1 day, ...hrs. or 15 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Twin Miscarriage

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country),

PARENTS.

10-NAME OF FATHER, Joseph Barber

11-BIRTHPLACE OF FATHER (city or town) Md (State or Country),

12-MAIDEN NAME OF MOTHER, Josephine Reese

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country),

14-

(Informant)

(Address)

JUN 15 1923

Robert P. Harrison; Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 14-23

17- I HEREBY CERTIFY, That I attended deceased from June 14, 1923, to June 14, 1923, that I last saw h[illegible] alive on June 14, 1923, and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Twin Miscarriage

Premature birth one hour

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

June 18, 1923 (Address) 14 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL, ...19....

20-UNDERTAKER.

ADDRESS

JUN

Should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—R. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76735

D76735

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2207 Brunt ST. 14 WARD

2-FULL NAME Clarence Maynard

(a) RESIDENCE. NO. 2207 Brunt ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 7, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	8	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Benj. Maynard

11 BIRTHPLACE OF FATHER (city or town) Baltimore.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Maggie Webster

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Bessie Maynard
(Address) 1131 Eutaw Av

15 Filed . Robert P. Harrison Registrar

UN 15 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/14 1923

17 I HEREBY CERTIFY, That I attended, deceased from 6/2/ 1923, to 6/14/ 1923
that I last saw him alive on 6/14/ 1923.
and that death occurred, on the date stated above, at 5.25 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) J. B. Hopkins M. D.
6/15/ 1923 (Address) 912 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Mt. Auburn Cemetery June 16 1923

20 UNDERTAKER — ADDRESS 1309
Jno. M. Johnson Druid Hill

mation should be carefully supplied. AGE should be stated EXACTLY. Information may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76736

D76736

CERTIFICATE OF DEATH.

REGISTERED NO. 9

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 E 25 St ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carol Jewel Pinkerton

(a) RESIDENCE NO. 1511 E 25 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER John Pinkerton

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Henrietta Kuemmerle

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Mrs. John Pinkerton
(Address) 1511 E 25 St

15 Filed , 19 Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to June 15, 1923,

that I last saw her alive on June 15, 1923,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. — mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Fritz J Lemmy, M. D.

(Address) 2700 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL Jun 16 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E Pratt

N.B.—WRITE with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76737 HEALTH DEPARTMENT—CITY OF BALTIMORE D76737

CERTIFICATE OF DEATH. 1557 Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2814 N. Y. Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Sarah M. Watts

(a) Residence No.... 2814 N. Y. Ave St.,..... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Homer B Watts

6-DATE OF BIRTH (month, day and year) Dec 30 1853

7-AGE, 70 yrs. mos. ds.

If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEDENT

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm T Hogg

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Martha Correll

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Harry W Adams

(Address) 2814 N. Y. Ave

15- Filed ..... 19.. Robert P. Harrison, Registrar.

UN 15 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 13

17- I HEREBY CERTIFY, That I attended deceased from June 2 1923 to June 13 1923

That I last saw h... alive on June 13 1923

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes - Kentucky

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralysis - 3 days

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Baltimore DATE OF BURIAL, June 16, 1923

20-UNDERTAKER, Wm Cook ADDRESS 1021 E. N. Ave

Should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76738

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76738

CERTIFICATE OF DEATH.

50

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 21 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Miller

(a) RESIDENCE No. 101 W. Rogers Ave (ST., Sterling Terr WARD)
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abner Miller

6 DATE OF BIRTH (month, day, and year) Jan 31 1850

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or.....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Kingston (State or country) N.Y.

PARENTS

10 NAME OF FATHER John Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.Y.

12 MAIDEN NAME OF MOTHER Jane McCabe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.Y.

14 Informant (Address) Charles Hunt 101 W. Rogers Ave.

15 Filed JUN 15 1923 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-10-1923

17 I HEREBY CERTIFY, That I attended deceased from 5-5-1923, to 6-10-1923, that I last saw h[illegible] alive on 6-10-1923, and that death occurred, on the date stated above, at 11.10 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
& exhaustion

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Exam,

(Signed) H. J. Barr, M. D.

6/15/1923 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: June 18 1923

20 UNDERTAKER: Wm Cook & Co — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76739

D76739

CERTIFICATE OF DEATH.

118-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltl Gen'l Hosp. ST. 2+ WARD)

2-FULL NAME Robert F Strauss

(a) RESIDENCE NO. 1508 Bayly Pl ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 27, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4-8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Chas. Strauss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Herzberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Chas. Strauss 1508 Bayly Pl.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1923

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1923, to June 13, 1923, that I last saw him alive on June 13, 1923, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows: Acute Cardiac Dilatation

(duration) yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Interussusception

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 5/23

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL 6/16/1923

20 UNDERTAKER Margaret E. Flynn

ADDRESS 1412 Eutaw Pl.

JUN 15 1923

Robert P. Harrison, Registrar

Burial Permit Clerk.

B.—WHITE PLAINLY, with ink. AGE should be stated EXACTLY. PHYSICIAN should be careful supplied. AGE should be mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

163652
D76740

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76740

CERTIFICATE OF DEATH.

91-002
REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. " " ST., 10 WARD)

2-FULL NAME John Rogers.

(a) RESIDENCE NO. 717 Ensor St. City ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a (If married, widowed, or divorced) HUSBAND of (or) WIFE of Henrietta Rogers (wife)

6 DATE OF BIRTH (month, day, and year) March 17, 1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
55	2	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Oyster Shucker
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS
10 NAME OF FATHER: John Rogers
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.
12 MAIDEN NAME OF MOTHER: Lydia Stuart
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Johns Hopkins Hospital. (Address) Records

JUN 16 1923 Robert P. Harrison, .19 Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1923

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1923, to June 13, 1923,
that I last saw him alive on June 13, 1923,
and that death occurred, on the date stated above, at 12³⁰ P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Mesenteric Vascular Occlusion (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Chas. R. Bagg, M. D.
.19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. | DATE OF BURIAL: June 16 1923

20 UNDERTAKER: Thos J. G. Locke | ADDRESS: 1302 Jeffers

B—WRITE PLAINLY, with ink or indelible pencil. AGE should be stated EXACTLY. PHYSICIANS should supply information. AGE should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH may be properly classified. It may be properly classified in plain terms, so that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76741

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76741

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1270 Sargent St. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Warren R. Keefer

(a) RESIDENCE NO. 1270 Sargent St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 ~~Single~~, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	2	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Charles R. Keefer

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Mary Flack

13 BIRTHPLACE OF MOTHER (city or town) Baltimore County
(State or country)

14 Informant Charles R. Keefer
(Address) 1270 Sargent St

15 Filed JUN 16 1923 Robert F. Garrison; Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1923, to June 15, 1923,
that I last saw him alive on June 15, 1923,
and that death occurred, on the date stated above, at 2 45 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) ....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? V

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. McGuire Jr M.D. M. D.

June 16 1923 (Address) 82 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cy — DATE OF BURIAL: June 18 1923

20 UNDERTAKER: Jos Loerdans & Son — ADDRESS: 2173 Pac

N.B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIAN'S mation should be carefully supplied. AGE, so that it may be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76742

CERTIFICATE OF DEATH.

44

D76742

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home-Infirmary ST., 61 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Reese Cassard

(a) RESIDENCE NO. 212-E-Biddle-St. ST., 11 WARD (Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 7 mos. 17 ds. How long in U. S., if of foreign birth? 76 yrs. 7 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jesse Lippincott Cassard

6 DATE OF BIRTH (month, day, and year) October-27-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Smith Reese

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emiline Reigert

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Jesse L. Cassard (Son)

(Address) 212-E-Biddle-St., City.

15 JUN 16 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1923

17

I HEREBY CERTIFY, That I attended deceased from May 21st, 1923, to June 14, 1923,

that I last saw h~~e~~ alive on June 14, 1923

and that death occurred, on the date stated above, at 1:05 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Liver

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of May 21 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Richard G. Hoblitzell, M. D.

, 19 (Address) Church Home and Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: June-16-23

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Supt.)

ADDRESS: 108 W. NORTH AVE.

B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76743

CERTIFICATE OF DEATH.

100-001

D76743

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. " " " ST., 3 WARD)

2-FULL NAME Baby Hennegan, City.

(a) RESIDENCE NO. 312 S. Dallas St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of Mary Hennegen (mother)

6 DATE OF BIRTH (month, day, and year) May 21-23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2/	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) ?

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records.

Filed JUN 16 1923 . 19

Robert F. Harrison, Registrar

~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1923

17 I HEREBY CERTIFY, That I attended deceased from June 11 , 1923 . to June 11 , 1923.

that I last saw h alive on June 11, , 1923.

and that death occurred, on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) yrs. — mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) A. A. Weech, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JUN 15 1923

Commissioner Health.

B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76744

D76744

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Fifth Ave nun Cole Ave 96 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Catherine Dehm

(a) Residence No. Fifth Ave nun Cole St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds How long in U. S., if of foreign birth 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Dehm

6-DATE OF BIRTH (month, day and year) June 19 1850

7-AGE, 72 yrs. 11 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Henry Neunsiter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Mrs Chas Dehm

(Address) Fifth Ave nun Cole

15- Robert P. Harrison,

Filed..... 192 Registrar.

JUN 5 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 14-23

17- I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred, on the date stated above, at 1.30 a m.

The CAUSE OF DEATH* was as follows:

..... Bronchial Cortune.....

.....

.....

.....(Duration) 10 yrs. mos. ds.

CONTRIBUTORY. Mitral Regurgitation
(Secondary)

.....(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed)..... M. D.

....., 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Carmel

DATE OF BURIAL, June 17, 1923

20-UNDERTAKER, K Freeman

ADDRESS 32 S Broadway

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76745

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76745

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 Elder Alley St. 17 WARD)

2-FULL NAME Ida Jackson

(a) RESIDENCE NO. 813 Elder Alley St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Jackson

6 DATE OF BIRTH (month, day, and year) Dec 23. 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jas. H. Emery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lucinda Halley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Jackson (Address) 813 Elder Alley

15 Filed JUN 16 1923, 19 Robert P. Garrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 9th, 1923, to June 14th, 1923, that I last saw h[illegible] alive on June 13th, 1923, and that death occurred, on the date stated above, at 1 50 P.M.

The CAUSE OF DEATH* was as follows: Pneumonia Phthisis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

6/15, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 6-18-1923

20 UNDERTAKER Daniel Easter — ADDRESS 916 Pine

S. B.—WRITE PLAINLY, WITH UNFADING INK. Spaces should be filled. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S certificate should be complete and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76746

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-002

D76746

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. 13 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lillie Sies

(a) RESIDENCE NO. 3327 Chestnut Ave., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: 7

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: David Sies.

6 DATE OF BIRTH (month, day, and year): [illegible] 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm. Long

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Sarah Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Current Hospital records

15 Filed JUN 16 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/15 1923

17 I HEREBY CERTIFY, That I attended deceased from 5/30, 1923, to 6/15, 1923, that I last saw her alive on 6/15, 1923, and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Thyroid Toxicosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Baetjer, M. D.

, 19 (Address) Current Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Union Chapel Cem. | DATE OF BURIAL: June 18, 1923

20 UNDERTAKER: R. S. Marshall | ADDRESS: 339 Fall Rd.

N.B.—WRITE PLAINLY, WITH INK AND IN INDELIBLE PENCIL. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76747

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76747

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 39 N. Bruce ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Bond.

(a) RESIDENCE NO. 39 N. Bruce ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored.	Widowed

5a If married, widowed, or divorced (or) WIFE of James Henry Bond.

6 DATE OF BIRTH (month, day, and year) 2-26-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	61	3	20.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Roxbury, Md.
(State or country)

PARENTS

10 NAME OF FATHER James Jones.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) District of Columbia

12 MAIDEN NAME OF MOTHER Mary Warfield

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Effie Thomas.
(Address) 1111 Etting St.

15 JUN 16 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1923

17

I HEREBY CERTIFY, That I attended deceased from April 10 , 19 23 , to June 15 , 19 23 ,

that I last saw h[illegible] alive on June 12 , 19 23 ,

and that death occurred, on the date stated above, at 4:25 [illegible] m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? auscultation & physical signs

(Signed) Chester Kiland, M. D.

6-15, 19 23 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 17, 1923

20 UNDERTAKER ADDRESS

Robert C. Williams, 1511 McElderry St.

B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC[illegible] PA-TION is very important. See instructions on back of certificates.

K.O.D.A.K.S.A.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76748

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76748

CERTIFICATE OF DEATH.

74-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 922 E Eager St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Annie C. McNamara

(a) Residence No. 922 E Eager St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Feb. 17 1875

7-AGE, 48 yrs. 4 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Matthew McNamara

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Catherine Feeney

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- Sister (Informant) Mrs. Catherine H. Eyland

(Address) 922 E Eager St

15- Filed JUN 16 1923 Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 14 1923

17- I HEREBY CERTIFY, That I attended deceased from Mar 12 1923 to June 14 1923

that I last saw her alive on....., 19.....,

and that death occurred, on the date stated above, at 2.16 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 7 hours

CONTRIBUTORY (Secondary) Cardiac hypertrophy

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? Do not know.

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs Stethoscope & percussion

(Signed) M. F. Voegler M. D.

6. 15. 1923 (Address) 1028 Valley St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
New Cathedral	June 16 1923

20-UNDERTAKER.	ADDRESS
E. W. Conklin	924 E Eager St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76749

CERTIFICATE OF DEATH.

X 186-00 D76749

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo Worden

(a) RESIDENCE NO. Hopeland md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

GE should be stated EXACTLY. PHYSICIANS shou[ld] state
at it may be properly classified. Exact statement of OCCUPA-
s on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colrd	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	57			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Don't Know

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country)

14 Informant Kidd
(Address) Hopeland Md

15 Filed JUN 16 1923, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 25 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(inquest, autopsy or inquiry.)~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema
due to Fracture of Pelvis & Ruptured Bladder

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Accidentally run over by Car

(duration) yrs. mos. ds.

(Signed) H. H. Young M. D.
(Coroner.)

6-16, 1923 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick Md

DATE OF BURIAL 6/17 1923

20 UNDERTAKER E. C. Eberly

ADDRESS Frederick Md

Spec—12-23-21—E.B.R.S.—400 Bks.

D76750

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76750

CERTIFICATE OF DEATH.

74-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augustus Rigger

(a) Residence No. Preston & Valley St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5yrs ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~single~~, Married, ~~Widowed~~, or ~~Divorced~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ Mary E. Burgar

6-DATE OF BIRTH (month, day and year) 24 July 1840

7-AGE. 82 yrs. 10 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Nothing

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS

10-NAME OF FATHER, Lawrence Rigger

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Martha Dinsmore

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Maryland

14- (Informant) Sister Florence

(Address) Little Sisters of the Poor

15- Filed ..... Robert P. Harrison, Registrar.

N16 1923 Burial Permit Clerk.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 15

17- I HEREBY CERTIFY, That I attended deceased from Arterio sclerosis ..... 19..... to ..... 19.....

that I last saw h. ~~WIFE~~ alive on June 10 19 23

and that death occurred, on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

Unknown (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

June 15 (Signed) F. A. Warner M. D

19 23 (Address) 433 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
New Cathedral	June 18 1923
20-UNDERTAKER.	ADDRESS
Josiah Sypher & Son	1600 W North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is ... See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D76751

D76751

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 Etting St.; 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ruth B. Saunders

(Residence in Baltimore: No. 1215 Etting St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH, ... (Month) May (Day) 10, (Year) 1911

7-AGE, 12 yrs. 2 mos. 4 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) School girl

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Walter Saunders

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Carrie E. Wilson

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Wm. .....

(Address) 1215 Etting St.

15-JUN 16 1923 Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June - 14, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 14 1923, to June 14 1923, that I saw her alive on June 12 1923, and that death occurred, on the date stated above, at 12.40 m.

The CAUSE OF DEATH* was as follows:

Chronic Ulcerative Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Appendicitis

(Duration) 1 yrs. 6 mos. ds.

(Signed) L. B. Hirschberg M. D.

June 14, 1923 (Address) 1401 E. Hill St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Mem | DATE OF BURIAL, June 16 1923

20-UNDERTAKER Frank Hemsley | ADDRESS [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be very careful in filling out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be important. See instructions on back of certificate.

Spec.—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76752

D76752

CERTIFICATE OF DEATH.

100-001

5

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Antone Victor

(a) Residence No.... 100 N. Front St St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1864

7-AGE. 58 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Pianist

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). (State or Country). Ohio

PARENTS

10-NAME OF FATHER. Wm. Victor

11-BIRTHPLACE OF FATHER (city or town). (State or Country). Pennsylvania

12-MAIDEN NAME OF MOTHER. S. Punatce

13-BIRTHPLACE OF MOTHER (city or town). (State or Country). Vermont

14- (Informant) Municipal Hospital Records

(Address)

15- Filed ..... 192.

Robert F. Harrison
Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 12, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 4 1923 to June 12 1923

that I last saw h. im alive on June 11 1923

and that death occurred, on the date stated above, at 1:00 A.M.

The CAUSE OF DEATH* was as follows:

Cholelithiasis

Acute Pancreatitis (Bilateral)

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (Terminal) (Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. M. Shipley M. D

6-13-23 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND.

DATE OF BURIAL. JUN 16 1923

20-UNDERTAKER.

ADDRESS.

JUN 16 1923

Commissioner Health

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

189

JUN 16 1923

6-78

Spec—12-23-21—E.B.R.S.—400 Bks.

D76753

D76753

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick W. Edwards

(a) Residence No. Bay View Hospital. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): 1842

7-AGE: 81 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED:

(a) Trade, profession, or particular kind of work: Gold Dilder

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore, Md.

PARENTS:

10-NAME OF FATHER: ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country): ?

12-MAIDEN NAME OF MOTHER: ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): ?

11- (Informant) Municipal Hospital Records

(Address)

15- Filed JUN 16 1923 19?

Robert F. Horsley
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 14, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 9 19 12 to June 14 19 23

that I last saw h. im alive on June 14 19 23

and that death occurred, on the date stated above, at 2:00 P. M.

The CAUSE OF DEATH* was as follows:

Senility

Senile Dementia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Terminal) (Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. M. Shipley M. D

6-15-23 Address Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL, 19....

20-UNDERTAKER.

ADDRESS

JUN 16 1923

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

189

Spec.—1-10-21—M&T—1500 Bks.

D76754

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76754

154-003

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 E Biddle ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Eleanor Graham

(a) RESIDENCE NO. 914 E Biddle ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 6/2/23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
			13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City (State or country)

PARENTS

10 NAME OF FATHER Harry Graham

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Ella Chilcote

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Harry Graham (Address) 914 E Biddle St

15 Filed JUN 16 1923 Registrar Robert P. HARTIGAN, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15 1923

17 I HEREBY CERTIFY, That I attended deceased from 6/2 , 1923, to 6/15 , 1923, that I last saw her alive on 6/15 , 1923, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Convulsions of cerebral origin

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Dr Bernard Wolff, M. D.

, 19 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral DATE OF BURIAL June 16 1923

20 UNDERTAKER H. C. Wiedefeld ADDRESS 914 Fremont Av

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of date TION is very important. See instructions on back of certificates. OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D76755

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76755

CERTIFICATE OF DEATH.

118-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 S. Glover ST., 1 WARD)

2-FULL NAME Warner W. Coleman

(a) RESIDENCE NO. 715 S. Glover ST., 1 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Fannie Coleman

6 DATE OF BIRTH (month, day, and year) Feb 13th 1851

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
72	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Tow Boat

(b) General nature of industry, business, or establishment in which employed (or employer) Captain

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John Coleman

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Harriett Wormack

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Fannie Coleman (Wife)
(Address) 715 S. Glover St

Filed JUN 16 1923 Robert P. Harrison
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 14 9 am, 1923, to June 15, 1923, that I last saw him alive on June 14 5 P.M., 1923, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Rupture Intestine

(duration) yrs. mos. 24 hours da.

CONTRIBUTORY (Secondary) Inspection Board -

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edgar N Otheys, M. D.

June 16, 1923 (Address) 100 S Patterson Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	June 18 1923

20 UNDERTAKER	ADDRESS
Lilly + Zeiler	403 S Wolfe

Spec.—1-10-21—M&T—1500 Bks.

D76756

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76756

CERTIFICATE OF DEATH.

44

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2041 Bank ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Coughlan

(a) RESIDENCE NO. 2041 Bank ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 9 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Karan Coughlan

6 DATE OF BIRTH (month, day, and year) Sept. 4th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thos. Murdock

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary Daly

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Thomas J. Coughlan (Address) 2041 Bank St.

15 Filed JUN 16 1923 19 Albert F. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1923

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to June 15, 1923, that I last saw her alive on June 14, 1923 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M. D.

6/16, 1923 (Address) 839 S. Ellwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	June 18 1923
20 UNDERTAKER Lilly & Zeiler	ADDRESS 408 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRIES should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D76757 HEALTH DEPARTMENT—CITY OF BALTIMORE D76757

CERTIFICATE OF DEATH. 181-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 808 Washington Boul. ward 19 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... Charles E Arnold

(Residence in Baltimore: No. 1417 W Pratt St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH, May (Month) 17 (Day) 1883 (Year)

7-AGE,	If LESS than 1 day,
4 yrs. 8 mos. 28 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Foreman
(b) General nature of industry, business, or establishment in which employed (or employer) Balto Tube Wks

9-BIRTHPLACE, (State or Country), Balto City

PARENTS.

10-NAME OF FATHER, John Arnold

11-BIRTHPLACE OF FATHER, (State or Country), Balto City

12-MAIDEN NAME OF MOTHER Annie Brady

13-BIRTHPLACE OF MOTHER, (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles E Arnold

(Address) 1417 Scathems St

15- Robert P. Harrison, Registrar.

Filed JUN 6 1923 192.. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 14 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Conclusion by Coroner Probably Accident

(Duration) ..... yrs. Sudden ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James McFaul M. D. (Coroner.)

June 15 1923 (Address) 700 E Chase St

*State the ~~Disease~~ Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt. Olivet Cemetery	6-16 1923

20-UNDERTAKER, James Lipman Kem ADDRESS 1000 S. Paca St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76758

CERTIFICATE OF DEATH.

129 ✓ D76758

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 Briscoe ST. 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Sales

(a) RESIDENCE NO. 1020 Briscoe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Irving Sales

6 DATE OF BIRTH (month, day, and year) April 20 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	49	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) do

14 Informant Irving Sales

(Address) 1020 Briscoe st

15 Filed JUN 16 1923, 19 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1921, to June 15, 1923, that I last saw h~~er~~ alive on June 13, 1923, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 5 yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) 0 yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward Wrak, M. D.

, 19 (Address) 821 N. Dal PKAv.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL June 18 1923

20 UNDERTAKER James D'Ignan & Son

ADDRESS 1000 S. Pac st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S mation should be carefully supplied. AGE, should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76759

CERTIFICATE OF DEATH.

100-001

D76759

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Dunlap

(a) Residence No. St. Elizabeth's Home St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 30 1922

7-AGE. 1 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, James Dunlap

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Greig

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant)

(Address)

15- 19 Registrar.

Robert P. Harrison,

Burial Permit Clerk

0327

UN 15 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 12 1923

17- I HEREBY CERTIFY, That I attended deceased from 5-31, 1923 to 6-12, 1923 that I last saw h... alive on 6-12, 1923 and that death occurred, on the date stated above, at 12:35 P. M.

The CAUSE OF DEATH* was as follows:

Fract. Right Tibia & Fibula. Acute

(Duration) yr. mos. 13 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(Duration) yrs. mos. 13 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Signs

(Signed) A. J. Scarborough M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, ..., 19....

20-UNDERTAKER ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health.

JUN 16 1923

WHITE PENCIL ONLY should be used. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH carefully supplied. AGE should be in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Not due to accident
but was due to Rickets

Cor.—1-12-23—M&T—100 Bks.

38745

D76760

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76760

CERTIFICATE OF DEATH.

X 188-007

22

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General ST. Hospital WARD)

2-FULL NAME Newman C. Shiflett.

(a) RESIDENCE NO. 11 W. Lee St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ---yrs.---mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND) of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) May 11th. 1907.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16	1	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Basic City, Va.
(State or country)

PARENTS

10 NAME OF FATHER Andrew Shiflett.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Sidney Breeden.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Ralph Shiflett. (brother)
(Address) 11 W. Lee St.

15 Filed JUN 17 1923 ROBERT R. KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15th. 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidental fall from a motor cycle.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner)

June 16th 192 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?
Hanover St. bridge, June 15th. 1923.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Basic City Va. DATE OF BURIAL 6-17 1923

20 UNDERTAKER E O B Hale ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks. 38796

163925 D76761

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 65-002 D76761

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Mayberry

(a) RESIDENCE NO. 2713 Braddock Ave Ward Jeannette, Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel Mayberry

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Freight Conductor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 873

9 BIRTHPLACE (city or town) (State or country) ?

PARENTS

10 NAME OF FATHER James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Susie Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 JUN 17 1923 ROBERT R. KRAUTER, (Registrar) Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1923

17 I HEREBY CERTIFY, That I attended deceased from May 20 1923, to June 16 1923, that I last saw h alive on June 16 1923, and that death occurred, on the date stated above, at 4:35 P. m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(duration) yrs. 8 mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Stable Duty

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Hand Section

(Signed) Chas. W. Downing Lab. M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Allentown Pa — DATE OF BURIAL June 19 1923

20 UNDERTAKER Joseph Ahrens — ADDRESS 2218 Kay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓ D76762

D76762

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 Bevan ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Gross Wright.

(a) RESIDENCE NO. 815 Bevan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 11 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married.

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of William Wright

6 DATE OF BIRTH (month, day, and year) June, 19, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Sam Goss

11 BIRTHPLACE OF FATHER (city or town) Norfolk

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie Goss

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co.

(State or country) Maryland

14 Informant Charles Goss

(Address) 207 W. Hamburg

15 JUN 17 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June, 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 5, 1923, to June, 14 1923.

that I last saw her alive on June, 12, 1923.

and that death occurred, on the date stated above, at 9.30 a/m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Chr. Endocarditis (duration) Uncertain

18 Where was disease contracted if not at place of death? in rear of 400 Peach alley

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Sputum +

(Signed) Davis Franchini M. D.

6/15 1923 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL Jun 18 1923

20 UNDERTAKER John H. Toodin — ADDRESS 1122 Pitt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be answered. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D76763

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

182 D76763

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Pier 2 Pratt St St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E Dorsey

(Residence in Baltimore: No. 922 Warner St. St.; 45 yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: 1858
(Month) (Day) (Year)

7-AGE: 65 yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): 042

9-BIRTHPLACE (State or Country): Balto

PARENTS.

10-NAME OF FATHER: R. Dorsey

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Sarah — ?

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Dorsey

(Address) 922 Warner

15-

Filed ..... 192.....

JUN 17 1923

ROBERT R. KRAUTER
Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 13 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental drowning
(Fell off boat)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Alcoholism

(Duration).....yrs.....mos.....ds.

(Signed) Edward J. Riley M. D.
(Coroner)

June 16 1923 (Address) 16 S. Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: [redacted] Cemetery DATE OF BURIAL: June 17 1923

20-UNDERTAKER: John H. Scudieri ADDRESS 1412 Russell St

N. B.—Every item of information should be carefully supplied. A state CAUSE OF DEATH in plain terms, so that it may be is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76764

CERTIFICATE OF DEATH.

15 129

D76764

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4102 Ridgewood Av ST.: 15 WARD)

2-FULL NAME Margery A. Martenet

(a) RESIDENCE. NO. 4102 Ridgewood Av ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Martenet

6 DATE OF BIRTH (month, day, and year) Sept 21 1832

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) Old Age

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fla.

PARENTS

10 NAME OF FATHER Dr Wm D Conway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Francis A Mansby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant G. C. Martenet
(Address) 4102 Ridgewood Av

15 JUN 17 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1923

17 I HEREBY CERTIFY, That I attended deceased from May 15 1923, to June 15 1923, that I last saw h alive on June 13 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18* Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. G. Timm, M. D.

, 19 (Address) 3501 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL June 18 1923

20 UNDERTAKER Charles E. Franck — ADDRESS For Madison St

N. B.—WHITE PEARL INK ONLY SHOULD BE USED. PHYSICIANS should state age should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state information may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76765 D76765

CERTIFICATE OF DEATH.

1-PLACE OF DEATH The Colonial Hospital, 1122 N. Mount Street REGISTERED No. 90

CITY OF BALTIMORE: (No.) ST. 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Spurlin

(a) RESIDENCE No. 619 D. Fremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Spurlin

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
34				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Owner Soda Fountain

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Samuel Spurlin

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Benj. Spurlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Lewis 1439 E. Baltimore St.

15 FILED JUN 17 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15 1923

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1923, to June 15, 1923, that I last saw him alive on June 15, 1923, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart —

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. P. Robinson, M. D.

, 19 (Address) The Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pikesville Rosedale	June 17 19 23

20 UNDERTAKER Jacob Lewis ADDRESS 1439 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76766

CERTIFICATE OF DEATH.

74-001 D76766

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 N. Ann ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Wyman

(a) RESIDENCE NO. 3 N. Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 2 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isreal Wyman

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1439 E. Balto

15 Filed JUN 17 1923 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-17 19 23

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1923, to June 17, 1923, that I last saw her alive on June 16, 1923, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) David Levkin M. D.

6-17, 1923 (Address) 2238 E. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Cemetery DATE OF BURIAL June 17 1923

20 UNDERTAKER Jac Lewis ADDRESS 1439 E. Balto

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76767

CERTIFICATE OF DEATH.

44 D76767

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3110 Guyon Ave ST., 28 WARD)

2-FULL NAME Samuel J. Liggett.

(a) RESIDENCE NO. 3110 Guyon Ave ST., — WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word)
M.	W.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada A. Liggett.

6 DATE OF BIRTH (month, day, and year) July 26 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ....min.
	72	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Receiver - Lotions

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Mentholatum Co

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER James F. Liggett

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Bruce

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs Ada A. Liggett
(Address) 3110 Guyon Ave

15 JUN 17 1923 (SEAL) Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1923

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1922, to June 16, 1923, that I last saw him alive on June 14, 1923, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

about 2 yrs. mos ds.
(duration)

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Symptoms and physical signs

(Signed) J. F. Shenwell, M. D.

June 16 1923 (Address) 1126 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cem

DATE OF BURIAL June 19 1923

20 UNDERTAKER Dennis Bros

ADDRESS 1723 Pa Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76768

CERTIFICATE OF DEATH.

101-092

D76768

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Sorensen

(a) RESIDENCE NO. 418 W. Mulberry St., ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced, HUSBAND of (or) ~~WIFE of~~: Bertha Sorensen

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 4 yr | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Horseman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Denmark

PARENTS

10 NAME OF FATHER: Henry Sorensen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Denmark

12 MAIDEN NAME OF MOTHER: Christine Boger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Denmark

14 Informant (Address): Univ. Hospital records

15 FILED JUN 17 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/14 1923

17 I HEREBY CERTIFY, That I attended deceased from 5/25 , 1923 , to 6/14 , 1923 .

that I last saw him alive on 6/14 , 1923 .

and that death occurred, on the date stated above, at 3:50 a m.

The CAUSE OF DEATH* was as follows:

Benign hypertrophy of prostate 8

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) W M Faculty M. D

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Royal Cemetery

DATE OF BURIAL 6/18 1923

20 UNDERTAKER: W P Cook

ADDRESS 502 E Vath

N. B.—WRITE PLAINLY, with ink. AGE should be carefully supplied. Exact information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76769

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76769

CERTIFICATE OF DEATH.

89

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 Farrest. ST., 10 WARD)

2-FULL NAME George W. Rhoads.

(a) RESIDENCE NO. 1110 Farrest ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella E. Rhoads.

6 DATE OF BIRTH (month, day, and year) Nov 26-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R.R. Conductor

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Penn R.R Co. 073

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Cyrus E. Rhoads.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Matilda Applegath.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Ella E. Rhoads. (Address) 1110. Farrest St.

15 Filed JUN 17 1923, 19 ROBERT R. KRAUER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1923

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1923, to June 16, 1923.

That I last saw him alive on June 16, 1923

and that death occurred, on the date stated above, at 109 m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Few hours (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Dr. H Pearce, M. D.

, 19 (Address) 2105 E. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL 6/19 1923

20 UNDERTAKER William Cook ADDRESS 502 E Wash

N. B.—WRITE PLAINLY. WITHOUT ABBREVIATIONS. All items should be carefully supplied. AGE should be properly classified. Exact information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76770 D76770

CERTIFICATE OF DEATH.

13

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. 10 St., WARD)

2-FULL NAME Anna Rocca

(a) RESIDENCE NO. 1109 Proctor St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work school

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cin. Ohio.
(State or country)

PARENTS

10 NAME OF FATHER Frank Rocca

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Carmella Lombati

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant Frank Rocca
(Address) 1109 Proctor St.

15 Filed ..... 19..... Registrar

JUN 17 1923 ROBERT R. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1923 to June 16, 1923.

that I last saw her alive on June 16, 1923

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute dilitation of heart -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute nephritis. about

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Kroger M. D.

19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL June 18 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E Monument

N. B.—WRITE PLAINLY, WITH INK. ALL information should be carefully supplied. AGE should be given. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATTENTION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76771 ✓ 44 D76771

D76771

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 S Castle ST., 7 WARD)

2-FULL NAME George L Smith

(a) RESIDENCE NO. 411 S Castle ST., V WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Smith

6 DATE OF BIRTH (month, day, and year) April 10 - 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	73	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer Stationary

(b) General nature of industry, business, or establishment in which employed (or employer) Lumber mill 030

(c) Name of employer Heise & Lamb

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Barbara Smith (Address) 211 S Castel St

15 JUN 17 1923 Registrar ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-16 1923

17 I HEREBY CERTIFY, That I attended deceased from 6-15 , 1923 , to 6-15 , 1923 , that I last saw h[e] alive on 6-15 , 1923 , and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows: Carcinoma of liver

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? C L Lee M. D.

(Signed) ...

. 19 (Address) 270 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cemetery DATE OF BURIAL June 19 1923

20 UNDERTAKER William Cook ADDRESS 502 E Nath

N. B.—WRITE PLAINLY, WITH INK. All items should be supplied. AGE should be carefully supplied. Exact statement of information should be carefully classified. AGE should be carefully supplied, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76772

CERTIFICATE OF DEATH.

84 D76772

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 819 N Streeper ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Tysbord

(a) RESIDENCE NO. 819 N. Streeper ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Tysbord

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Frank Puchorka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Marie Rybalcek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant (Address) Joseph Tysbord 819 N Streeper st

15 Filed JUN 17 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to June 14, 1923, that I last saw h[illegible] alive on June 14, 1923, and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) F Frank Burgdorfer M. D.

(Address) 8000 Natl Wk Bl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: June 18 1923

20 UNDERTAKER: Frank Enoch & Son — ADDRESS: 1900 Eastern Ave

N. B.—WRITE PLAINLY. All items should be carefully supplied. Age should be properly classified. Exact information should be carefully supplied. Age should be carefully supplied. Exact information should be carefully supplied. Age should be carefully supplied. Exact information should be carefully supplied. Age should be carefully supplied

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No autopsy

Spec.—8-24-14—M. & T.—2000 Blks.

D76773

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76773

CERTIFICATE OF DEATH.

REGISTERED No. C 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 114 S. Washington ST.; V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William August Weniger

(Residence in Baltimore: No. 114 S. Washington St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept. (Month) 25 (Day), 1901 (Year)

7-AGE, 71 yrs. 8 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph Weniger

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Barbara Stach

13-BIRTHPLACE OF MOTHER (State or Country), Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara Weniger

(Address) 114 S. Washington St.

15- JUN 17 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 17 (Day), 1923 (Year).

17- I HEREBY CERTIFY, That I attended deceased from April 18th 1923, to June 17 1923, that I saw him alive on June 13 1923, and that death occurred, on the date stated above, at 6 40 Am.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6/12 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed), Leonard E Beach M. D.

June 18, 1923 (Address) 2331 St Paul St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, June 18, 1923

20-UNDERTAKER Lilly & Zeiler ADDRESS 403 S Wolfe

N.B.—Every item of information should be carefully obtained, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D76774

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7H-001 D76774

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 117 E. Washington St. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth C. Russum

(a) RESIDENCE NO. 117 E. Washington St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter P. Russum

6 DATE OF BIRTH (month, day, and year) Sept. 25-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66.	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER George Michael

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Emma Linder.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Peter P. Russum

(Address) 117 E. Washington St

15 Filed JUN 17 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1923, to June 14, 1923, that I last saw her alive on June 13, 1923, and that death occurred, on the date stated above, at 6.00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. 2 mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Levering M. D.

June 16, 1923 (Address) Ten Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL June 19 1923.

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Hoffman

N. B.—WRITE PLAINLY, WITH INK. AGE should be carefully supplied. Exact statements mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

162348 # D76775

CERTIFICATE OF DEATH.

51 D76775

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 20 WARD)

2-FULL NAME Charles Sibiski

(a) RESIDENCE NO. 3711 Foster Ave. City ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (HUSBAND) (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 26, 1914.

7 AGE: Years 9 Months — Days 20. If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Sibiski.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Freda ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Johns Hopkins Hospital Freeda

15 Filed JUN 17 1923 Registrar ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 14 1923

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1923, to June 14, 1923, that I last saw him alive on June 14, 1923, and that death occurred, on the date stated above, at 7.25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis (rheumatic origin)

(duration) yrs. 18 mos ds.

CONTRIBUTORY (Secondary): Cardiac decompensation (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. A. Wesch, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. DATE OF BURIAL: June 18 1923.

20 UNDERTAKER: Lilly and Zile ADDRESS: 403 S. Wolfe

N. B.—WRITE PLAINLY, with pencil supplied. AGE should be carefully supplied. EXACT information should be carefully classified. AGE should be carefully supplied. EXACT information should be carefully classified. AGE should be carefully supplied. EXACT information should be carefully classified

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D76776

REGISTERED NO. C

D76776

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 600 E. Clement ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Conrad Schaefer (If not, then) St.; 38 yrs., mos., da.)

(Residence in Baltimore: No. 600 E. Clement

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~SINGLE~~ MARRIED, WIDOWED, OR ~~DIVORCED~~, (*Write* the word.) Widower

6-DATE OF BIRTH. Feb 19 (Month) (Day), 1850 (Year)

7-AGE. 73 yrs. 4 mos. 28 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Conrad Schaefer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. Hopf

(Address) 600 E. Clement

15- JUN 17 1923 ROBERT R. KRAUTER, Burial Permit ~~Clerk~~.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 11 1923, to June 16 1923, that I saw him alive on June 16 1923, and that death occurred, on the date stated above, at 4:40 Am.

The CAUSE OF DEATH* was as follows:

Carcinoma Cervix

(Duration) yrs. mos. 15 da.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. da.

(Signed) [illegible] M D.

June 16, 1923. (Address) 919 E. Lombard St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 21 yrs. mos. da. In the State 72 yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence 600 E. Clement St

19-PLACE OF BURIAL OR REMOVAL. London PK Cemetery

DATE OF BURIAL. 6-18, 1923

20-UNDERTAKER Geo Leimbach & Son

ADDRESS 647 W Fayette St

N.B.—Every item of information should be entered, so that it may be properly classified. CAUSE OF DEATH in plain terms, as important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76777

CERTIFICATE OF DEATH.

91-002 D76777

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 Bryle ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Henry Steinhauer

(a) RESIDENCE NO. 1530 Bryle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Schneider

6 DATE OF BIRTH (month, day, and year) Jan 13 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
	65	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Chas Applegate

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER George Steinhauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Heinzbuger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Kate Steinhauer (Address) 1530 Bryle St

15 JUN 17 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1923

17 I HEREBY CERTIFY, That I attended deceased from June 11. 1923. to June 16. 1923.

that I last saw he alive on June 16. 1923.

and that death occurred, on the date stated above, at 8-4 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) arteriosclerosis.

(duration) 5 yrs. mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs.

(Signed) Sidney H. Street M. D.

6/16 1923 (Address) 405 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL June 19 1923.

20 UNDERTAKER Wm Cook — ADDRESS 502 E Pratt

N. B.—WRITE PLAINLY with pen and ink. AGE should be carefully supplied. Exact statement may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76778

CERTIFICATE OF DEATH.

90 : D76778

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 628 N. Bruce St ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Stewart

(a) RESIDENCE NO. 628 N. Bruce St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40X yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Stewart

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
65 ?				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Job work

(c) Name of employer Unemployed

9 BIRTHPLACE (city or town) (State or country) Howard Co.

PARENTS

10 NAME OF FATHER John Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Harriet Burges

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Susie Hill (Daughter)

(Address) 628 N. Bruce St.

15 JUN 17 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15th 1923

17

I HEREBY CERTIFY, That I attended deceased from June 12th. 1923 to June 15th. 1923,

that I last saw h im alive on June 15th. 1923, 19 ,

and that death occurred, on the date stated above, at 9:30 p. m.

The CAUSE OF DEATH* was as follows:

Broken Compensation (Cardiac)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Mitral Ins.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Sprecher M. D.

, 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 6-18- 1923

20 UNDERTAKER David Easton

ADDRESS 116 Penna Ave

N. B.—WRITE PLAINLY, with pencil. AGE should be carefully supplied. Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE OF BURIAL and ADDRESS of UNDERTAKER are very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76779 ✓ D76779

D76779

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 614 William Street St., 22 84 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Elizabeth Robbins

(a) Residence No. 614 William St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 30, 1922

7-AGE. ....yrs. 10 mos. 16 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, William Robbins.

11-BIRTHPLACE OF FATHER (city or town) Balto. (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Lillian Bennett

13-BIRTHPLACE OF MOTHER (city or town) Balto. (State or Country), Md.

14- (Informant) Wm. Robbins.

(Address) 614 William St.

JUN 17 1923 19.. ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 16, '23

17- I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923 to June 16 1923 that I last saw h...er alive on June 14, 1923 and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Idiocy (Mongolian)

Scurvy

(Duration) yrs. 10 mos. 16 ds

CONTRIBUTORY (Secondary) Convulsion

(Duration) yrs. mos. 1 ds

18-Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Cockeran M. D

6/16, 1923 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral. DATE OF BURIAL, 6/18/23 19....

20-UNDERTAKER. Fred G. Krauser & Son. ADDRESS 703 Hanover St.

N. B.—Write plainly. AGE should be carefully supplied. Exact statement of date of birth should be carefully supplied. AGE should be properly classified. Exact statement of occupation should be carefully supplied. AGE should be properly classified. Exact statement of cause of death should be carefully supplied. AGE should be properly classified. Exact statement of cause of death should be carefully supplied. AGE should be properly classified. Exact statement of cause of death

Spec.—1-10-21—M&T—1500 Bks.

D76780

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-002 D76780

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 680 Sarah Ann ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Lindsay

(a) RESIDENCE NO. 680 Sarah Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 9, 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Quaker Neck Md

PARENTS

10 NAME OF FATHER: John Lindsay

11 BIRTHPLACE OF FATHER (city or town) (State or country): Queen Anne Co Md

12 MAIDEN NAME OF MOTHER: Mary Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Quaker Neck Md

14 Informant: George Carr

(Address) 680 Sarah Ann

JUN 17 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1923, to June 15, 1923, that I last saw her alive on June 14, 1923, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D F Revill M. D.

(Address) 1191 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lakewood Beach Cem

DATE OF BURIAL: June 18 1923

ADDRESS 1631 Orleans St

20 UNDERTAKER: Edward Bryson

N. B.—WRITE PLAINLY, AGE must be properly classified. Age should be carefully supplied. Age information should be carefully supplied. Age should be carefully supplied. Age information should be carefully supplied. Age should be carefully supplied. Age information should be carefully supplied

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

76781 D76781 — 44 D76781 — REGISTERED NO.

1-PLACE OF DEATH — CITY OF BALTIMORE: (No.) Hebrew Hospital ST., 5 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Lieberman

(a) RESIDENCE NO. Hebrew Aged Home 105 Asquith St. ST., WARD (If non-resident give city or town and State)
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Lena (Address) 1439 E. Baltimore St

15 JUN 17 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1923, to June 15, 1923, that I last saw h[illegible] alive on June 15, 1923, and that death occurred, on the date stated above, at 4 1/2 m.

The CAUSE OF DEATH* was as follows:
Carcinoma of Gall Bladder

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Isidor [illegible], M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 6-17-1923

20 UNDERTAKER Fact Lena — ADDRESS 1439 E. Balto

N. B.—WRITE PLAINLY, WITH INK. AGE should be properly classified. Exact statement should be carefully supplied. AGE should be carefully supplied, so that it may be properly classified. Exact information should be carefully supplied, so that it may be properly classified. Exact statement

Spec.—1-10-21—M&T—1500 Blks.

16 H H 50

HEALTH DEPARTMENT—CITY OF BALTIMORE

✓ 7678 2

31 D76782

CERTIFICATE OF DEATH.

D76782

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.

2-FULL NAME Martin Aptaker

(a) RESIDENCE NO. 1514 Madison Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Sept 18 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or..... min.
		9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10 NAME OF FATHER German

11 BIRTHPLACE OF FATHER (city or town) (State or country) Illinois

12 MAIDEN NAME OF MOTHER Flora Rubinstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 JUN 17 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15 , 1923, to June 17 , 1923, that I last saw h live on June 17 , 1923, and that death occurred, on the date stated above, at 5-25 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis,

(duration) 0 yrs. 2 mos 9 ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) 0 yrs. 0 mos. 9 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Examination of cerebro spinal fluid

(Signed) William H. F. Wartten, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel DATE OF BURIAL June 17 1923

20 UNDERTAKER Jacot Lewis ADDRESS 1428 E. Biddle

N. B.—WRITE PLAINLY. All items must be carefully supplied. AGE must be properly classified. Each item should be carefully supplied, so that it may be properly classified. Each information should be carefully supplied, so that it may be properly classified. Each information should be carefully supplied, so that it may be properly classified. Each information

D76783

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167-001 D76783

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1920 E. Lanvale St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert B. Cockran

(Residence in Baltimore: No. 1920 E Lanvale. St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. April 21 1888
(Month) (Day) (Year)

7-AGE. 35 yrs. 1 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Painter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Louis Cokran

11-BIRTHPLACE OF FATHER. (State or Country) Balto. Md.

12-MAIDEN NAME OF MOTHER. Mary Endutch

13-BIRTHPLACE OF MOTHER. (State or Country). Balto Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Cokran (wife)

(Address) 1920 E Lanvale St.

15- JUN 18 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 14 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Poisoning
Suicide

(Duration) 1 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) Geo. Claude Bladel M. D.
(Coroner)

June 15 1923 (Address) 1432 E. Biddle

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cem. DATE OF BURIAL. 6/18/ 1923

20-UNDERTAKER. Margaret J. Flynn ADDRESS 1422 Argyle Ave

N. B.—Every item of information should be given, so that it may be properly classified. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Name is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Blks.

D76784

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 D76784

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1025 N. Central Ave ST., 10 WARD)

2-FULL NAME Joseph J. Stellein

(a) RESIDENCE NO. 1025 N. Central Ave ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 3 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 2 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Frank A. Stellein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth E. Sporrer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr. Frank A. Stellein

(Address) 1025 N. Central Ave

15 JUN 18 1923 ROBERT H. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1923

17 I HEREBY CERTIFY, That I attended deceased from April 2 1923, to June 16 1923, that I last saw him alive on June 16 1923, and that death occurred, on the date stated above, at 11 55 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(duration) yrs. 2 mos. 13 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of — — —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) William F. Stewart M. D.

6/ 6, 19 (Address) 1200 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL June 16 1923

20 UNDERTAKER Henry Hoeck Son ADDRESS 1301 E. Eager St

N. B.—WRITE PLAINLY. All items must be carefully supplied. Age should be given in years, months and days, so that it may be properly classified. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Acute Rheumatic Fever

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76785

CERTIFICATE OF DEATH.

174 D76785

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1712 N. Patterson Park Av ST. 8 WARD)

2-FULL NAME Barbara Koerber

(a) RESIDENCE NO. 1712 N. Patterson Park Av ST., ..WARD ..
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. — mos. — ds. How long in U. S., if of foreign birth? 38 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~(or) HUSBAND of~~ (or) WIFE of John Koerber

6 DATE OF BIRTH (month, day, and year) May 19 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	—	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Peter J. Lohmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie A. Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. John Koerber
(Address) 1712 N. Patterson Park Av

15 Filed JUN 18 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 1921 to June 17 1923.

that I last saw her alive on June 16 1923

and that death occurred, on the date stated above, at 12 15 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) B. F. Herzog M. D.

June 17 1923 (Address) 1305 N. Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 19 1923
20 UNDERTAKER	ADDRESS
Henry Hauck Son	130 E Eager st

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. DATE OF BIRTH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76786

100-001

D76786

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Maryland General Hospital

CITY OF BALTIMORE: (No. 15 ST., WARD)

2-FULL NAME Richard a Wienecke

(a) RESIDENCE NO. 4609 Park Heights Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 23 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Alfred H. Wienecke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Martha Debus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Alfred H Wienecke

(Address) 4609 Park Heights Ave

15 Filed JUN 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE must be properly classified. CAUSE OF DEATH in plain terms, so that it may be understood by the public. See reverse side of certificates. See instructions on back of certificate. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1923, to June 17, 1923.

that I last saw him alive on June 17, 1923;

and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Syph)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Emphysema (Syph)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of June 16-1923

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James Hubert Wilkerson, M. D.

, 19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL June 19 1923

20 UNDERTAKER Henry Hoeck Son — ADDRESS 1301 E Eager

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (morely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76787

CERTIFICATE OF DEATH.

D76787

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Rennington - Cold Spring Lane WARD)

2-FULL NAME Mary Albert Pleasants

(a) RESIDENCE NO. Tampa, Idaho ST., ..WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred —yrs. 8 mos. —ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 4 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pupil at School

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Tampa, Idaho

PARENTS

10 NAME OF FATHER Wm. A Pleasants

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Frances J. Albert

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Dr. J. Hall Pleasants (Address) 201 Longwood Rd Roland Park

15 JUN 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1923

17 I HEREBY CERTIFY, That I attended deceased from May 7 1923, to June 15 1923, that I last saw he alive on June 15 1923, and that death occurred, on the date stated above, at 6.05 P. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) 40 days

CONTRIBUTORY (Secondary) Intestinal haemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? typhoid bacilli in blood

(Signed) J. Hall Pleasants M. D.

(Address) 201 Longwood Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem DATE OF BURIAL June 18th 1923

20 UNDERTAKER Henry W Jenkins Sons Co ADDRESS McCulloh & Orchard

N. B.—WRITE PLAINLY. All items should be carefully supplied. Age information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

John J. Finn

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76788 ✓ D76788

CERTIFICATE OF DEATH.

128

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hampden 3830 Hickory Ave ST. 43 WARD)

2-FULL NAME John J. Finn

(a) RESIDENCE NO. 3830 Hickory Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. — ds. How long in U. S., if of foreign birth? 55 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced (or) WIFE of Agnes. Finn

6 DATE OF BIRTH (month, day, and year) June 0 - 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	—	—	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) water board

(c) Name of employer city of Baltimore

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Patrick Finn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Madden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs John J. Finn

(Address) 3830 Hickory Ave Hampden

15 Filed JUN 18 1923

Registrar

ROBERT R. KRAUTER,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1923

17 I HEREBY CERTIFY, That I attended deceased from June 11th, 1923, to June 17th, 1923, that I last saw him alive on June 16, 1923, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Alcoholism (duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) David M. Thos Jenifer M. D.

6/7, 1923 (Address) Towson Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem. Towson — DATE OF BURIAL: June 19 1923

20 UNDERTAKER John Burns Son — ADDRESS Towson

...mation should be carefully written in plain terms, so that it may be properly ...
CAUSE OF DEATH in plain terms, so that it may be properly ... back of certificates.
TION is very important. See instructions on back.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76789 / D76789

CERTIFICATE OF DEATH.

113

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

D76789

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2224 Lamley ST., 6 WARD)

2-FULL NAME Clarence A. Uttenreither

(a) RESIDENCE NO. 2224 Lamley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY. All items must be carefully supplied. Abbreviations may be properly classified. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 6 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	1	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Chas. F. Uttenreither

11 BIRTHPLACE OF FATHER (city or town) Balto City
(State or country)

12 MAIDEN NAME OF MOTHER Anna Brown

13 BIRTHPLACE OF MOTHER (city or town) Richmond Va
(State or country)

14 Informant Anna Uttenreither
(Address) 2224 Lamley St

15 JUN 18 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1923, to June 16, 1923, that I last saw h[illegible] alive on June 16 1923, and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) John Boyd, M. D.

, 19 (Address) 1937 E Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. — DATE OF BURIAL June 18 1923

20 UNDERTAKER Geo. M. Fink & Son — ADDRESS 811 N Wolfe

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76790

CERTIFICATE OF DEATH.

38 D76790

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 1 ST., WARD)

2-FULL NAME Jacob Reich

(a) RESIDENCE NO. 2416 O'Donnell ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) July 17- 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mr. Zinner (Address) 18 S. Curley St.

15 JUN 18 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1923, to June 15, 1923, that I last saw him alive on June 15, 1923, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency; Syphilitic Aortitis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis

(Signed) Isidor D. Fury, M. D.

4/5, 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL June 18 1923

20 UNDERTAKER Zirkler + Zirkler

ADDRESS 1739 E. Eager St.

N. B.—WRITE PLAINLY, with ink. AGE should be carefully supplied. Information should be carefully supplied, so that it may be properly classified. Exact CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D76791

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D76791

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3023 Montebello Ave ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Martin Schuller

(a) RESIDENCE NO. 3023 Montebello Ave ST.; WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Amelia Schuller

6 DATE OF BIRTH (month, day, and year): Oct 2 1842

7 AGE: 80 Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Alice Ellis

(Address) 3023 Montebello Ave

15 Filed JUN 18 1923 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1923

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1923, to June 16, 1923, that I last saw him alive on June 15, 1923, and that death occurred, on the date stated above, at 4.20 A m.

The CAUSE OF DEATH* was as follows:

1 Hypostatic Pneumonia

(duration) yrs. mos 4 da.

CONTRIBUTORY (Secondary): Senile Arteriosclerosis (duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John T Lemmon M. D.

June 18 1923 (Address) 718 N Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery | DATE OF BURIAL: June 18 1923

UNDERTAKER: Wm Cook | ADDRESS: 502 E Nor

N. B.—WRITE PLAINLY. All items must be carefully supplied. Age should be properly classified. Information should be carefully supplied, so that it may be in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D76792

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

112 D76792

REGISTERED NO.

1-PLACE OF DEATH Southern Ave

CITY OF BALTIMORE: (No. Gardenville ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Alice Matthews

(a) RESIDENCE NO. Gardenville, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William O. Matthews

6 DATE OF BIRTH (month, day, and year): Dec 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Co.

PARENTS

10 NAME OF FATHER: John Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co.

12 MAIDEN NAME OF MOTHER: Margaret Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co.

14 Informant: George F. Couse

(Address) Swarthmore, Pa.

15 Filed JUN 18 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 15. 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 10, 1920, to June 15, 1923, that I last saw her alive on June 15, 1923, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Gastritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. D. Couse, M. D.

, 19 (Address) Gardenville Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Gunpowder Md.

DATE OF BURIAL 19

20 UNDERTAKER: Wm. C. Brooks

ADDRESS Sparks

N. B.—WRITE PLAINLY. All items must be carefully supplied. Any information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76793

CERTIFICATE OF DEATH.

57 D76793

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3450 Elm Ave. ST., 13 (WARD)

2-FULL NAME Ella J. Lidie

(a) RESIDENCE NO. 3450 Elm Ave. ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cyrus L. Lidie

6 DATE OF BIRTH (month, day, and year): Jan. 2-1879

7 AGE — Years: 44 — Months: 5 — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Maryland

PARENTS

10 NAME OF FATHER: Louis S. Hobbs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co Maryland

12 MAIDEN NAME OF MOTHER: Priscilla Hobbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co. Maryland

14 Informant (Address): Cyrus L. Lidie 3450 Elm Ave

15 JUN 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17 1923

17 I HEREBY CERTIFY, That I attended deceased from April, 1910, to June 17, 1923, that I last saw her alive on June 17, 1923, and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Arthritis Deformans

(duration) 19 yrs. mos da.

CONTRIBUTORY (Secondary): Arthritis

(duration) yrs. mos. 7 da.

18 Where was disease contracted if not at place of death? Balto. Co.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X-ray etc.

(Signed) [illegible] M. D.

June 18, 1923 (Address) 3429 Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's (Hampden)

DATE OF BURIAL: June 20 1923

20 UNDERTAKER: Horace H. Burgee

ADDRESS: 363 Stallo Rd.

N. B.—WRITE PLAINLY. All items must be carefully supplied. Age must be properly classified. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76794

CERTIFICATE OF DEATH.

179 D76794

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 304 S Poppleton ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Murphy

(a) RESIDENCE NO. 304 S Poppleton ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary A. McDonald Murphy

6 DATE OF BIRTH (month, day, and year) Jan 1 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Cafe keeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Daniel Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs Mary A. Murphy (Address) 304 S. Poppleton St.

15 JUN 18 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1923 to May 15, 1923; that I last saw him alive on May 15 1923 and that death occurred, on the date stated above, at 11.20 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. 2 mos. 11 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 16 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Pressure

(Signed) Edgar E Graves M. D.

, 19 (Address) 1570 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	June 16 19 23
20 UNDERTAKER	ADDRESS
Edgar E Graves	501 Hollins

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—1-10-21—M&T—1500 Blks.

D76795

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-901 D76795

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1348 James ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patrick Cavanaugh

(a) RESIDENCE NO. 1348 James ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Cavanaugh

6 DATE OF BIRTH (month, day, and year) Dec 23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer C+P Telephone Co Balto Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Catherine Cavanaugh (Address) 1348 James St

15 Filed JUN 18 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 15. 1923 to June 15 1923

that I last saw him alive on June 15 1923

and that death occurred, on the date stated above, at 10 45 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. One mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M D Sullivan M. D.

6-18-1923 (Address) 821 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet cemetery DATE OF BURIAL June 19 1923

20 UNDERTAKER James D'Ignan & Son ADDRESS 1000 S Paca St

N. B.—WRITE PLAINLY. All items must be carefully supplied. Information should be carefully supplied. Note that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76796

CERTIFICATE OF DEATH.

3 1 V

REGISTERED NO. D76796

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bowleys Lane ST., Gardenville WARD)

2-FULL NAME Mary A. Leidlich

(a) RESIDENCE NO. Bowleys lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph G Leidlich

6 DATE OF BIRTH (month, day, and year) June 5- 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER James Wiley

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Dignan

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant (Address) Joseph G. Leidlich Bowleys Lane Gardenville

15 JUN 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1 1923 to June 15 1923.

that I last saw h alive on June 15 1923.

and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows:

Exhaustion

Toxemia

(duration) yrs. mos ds.

CONTRIBUTORY, (Secondary) Pulmonary Tuberculosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas J Young M. D.

June 16, 1923 (Address) 4 W. Hartford ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL June 19 1923.

20 UNDERTAKER James Dignan & Son — ADDRESS 1000 S. Paca St

N. B.—WRITE plainly and carefully supplied. All information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76797

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76797

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Levi Edlavitch

(a) RESIDENCE NO. 1627 Bentalou St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa

— 1858

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Grocer and

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Levi 1439 E. Balto

15 JUN 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1923

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1923, to June 17, 1923, that I last saw him alive on June 17, 1923, and that death occurred, on the date stated above, at 3.30 A.m.

The CAUSE OF DEATH* was as follows:

myocarditis chronic.

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Edward H. Kotlowski, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn — DATE OF BURIAL 6-18-1923

20 UNDERTAKER Levi — ADDRESS 1439 Balto

N. B.—WRITE PLAINLY. Items must be carefully supplied. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D76798 (Neuman) D76798

HEALTH DEPARTMENT—CITY OF BALTIMORE 90

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 1619 Frederick Av St. 19 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise J. K. Neumann
(Residence in Baltimore: No. 1619 Frederick Av St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female
4-COLOR OR RACE. White
5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

6-DATE OF BIRTH. April (Month) 27 (Day) 1840 (Year)

7-AGE. 73 yrs. 1 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Housework

9-BIRTHPLACE. (State or Country) Germany

PARENTS

10-NAME OF FATHER. Hugo Kethe
11-BIRTHPLACE OF FATHER. (State or Country) Germany
12-MAIDEN NAME OF MOTHER. Catharine Koffa
13-BIRTHPLACE OF MOTHER. (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles Neumann
(Address) 2117 E. Preston St.

15- JUN 18 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 17 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:
Arterio-Sclerosis
(Duration) 10 Days mos. ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(Duration) Sudden yrs. mos. ds.

(Signed) James M. Hamilton M. D. (Coroner.)
June 17 1923 (Address) 700 E. Chase St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Leadenhall Cemetery DATE OF BURIAL. June 19 1923

20-UNDERTAKER. Josiah Pfeffer ADDRESS 1600 W. North Ave.

N. B.—Every item of information should be given, so that it may be properly entered on certificate. State CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate. This is very important.

Spec.—1-10-21—M&T—1500 Bks.

D76799/6442/6 HEALTH DEPARTMENT—CITY OF BALTIMORE D76799

CERTIFICATE OF DEATH. 100-80

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. WARD) REGISTERED NO.

CITY OF BALTIMORE: (NO. ST., (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Cwiklinski

(a) RESIDENCE NO. 828 S. Kenwood Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 23-1922

7 AGE Years 1 Months 1 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Ellie Rozzyk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 JUN 18 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15- 1923

17 I HEREBY CERTIFY, That I attended deceased from June 14 ,1923. to June 15 ,1923.

that I last saw h alive on June 15 ,1923, at 11-35 p. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. 1 mos 21 ds.

CONTRIBUTORY (Secondary) Empyema + pneumothorax

(duration) — yrs. 1 mos. 21 ds.

18 Where was disease contracted if not at place of death? Athens.

Did an operation precede death? No Date of —

Was there an autopsy? Yes Postmortem examination should be carefully supplied. Not that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

What test confirmed diagnosis? transparent

(Signed) William H. F. Wartheu, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. DATE OF BURIAL June 18 1923

20 UNDERTAKER Stephen J. Trankowski ADDRESS Wood & Hanover

Spec.—1-10-21—M&T—1500 Blks.

Dreesinger

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76800 / D76800

113

D76800

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1845 N. Chester St ST., 8 WARD)

2-FULL NAME John William Dreesinger

(a) RESIDENCE NO. 1845 N. Chester ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 15, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	0	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John H. Dreesinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John H. Dreesinger (Address) 1845 N Chester St

15 Filed JUN 18 1923 19 ... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1923, to June 18, 1923,
that I last saw him alive on June 16, 1923,
and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Gastric Enteritis acute

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jacob Frahm M. D.
6/18, 1923 (Address) 1828 N. Wash St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. — DATE OF BURIAL June 20, 1923

20 UNDERTAKER E. LeRoy Stifflar — ADDRESS 125 E North Ave

N. B.—WRITE should be carefully supplied. As mation should be properly classified. CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76801

HEALTH DEPARTMENT—CITY OF BALTIMORE D76801

CERTIFICATE OF DEATH. 158-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1610 N. Fulton Ave. ST., 15 WARD)

2-FULL NAME Jeanette Margaret Peters

(a) RESIDENCE NO. 1610 N. Fulton Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 23, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	4	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Stenographer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER Thomas Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country): Rhode Island

12 MAIDEN NAME OF MOTHER Mary Brady

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Thomas Peters,
(Address) 1610 N. Fulton Ave

15 Filed JUN 18 1923 ROBERT R. KRAUTER Registrar
Burial Permit Issued by Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 20th, 1923, to June 16th, 1923; that I last saw her alive on June 16th, 1923, and that death occurred, on the date stated above, at — 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilation

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Chlorosis (duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical & clinical.

(Signed) Wm J. Sullivan M. D.

6/17, 1923 (Address) 1701A Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bonnie Brae Cemetery

DATE OF BURIAL: June 19, 1923

20 UNDERTAKER: E. LeRoy Stiffler

ADDRESS: 125 E. North Ave

N. B.—Write plainly and fill all blanks. Information should be carefully supplied. Information may be properly classified CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D76802

D76802

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. I8I3 Wilhelm St. ST. 19 WARD)

2-FULL NAME Ruth Anna Stevens

(a) RESIDENCE NO. I8I3 Wilhelm St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Carles Stevens

6 DATE OF BIRTH (month, day, and year) November II, I892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30	7	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Harvey

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Skipper

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Carles Stevens
(Address) I8I2 Wilhelm St.

15 Filed JUN 18 1923 ROBERT R. KRANTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1923

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1923, to June 14, 1923,
that I last saw h alive on June 14, 1923,
and that death occurred, on the date stated above, at 4-30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(duration) yrs. 3 mos 2 ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms + Sputum

(Signed) James R. Lowndes M. D.
6/17, 1923 (Address) 1729 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL June 18 1923

20 UNDERTAKER Harry H. Witzke — ADDRESS 1531 W. Lombard St

N. B.—WRITE PLAINLY. All information should be carefully supplied. Accurate information is very important. See instructions on back of CAUSE OF DEATH in plain terms, so that it may be properly classified. NOTICE

Spec.—1-10-21—M&T—1500 Bks.

D76803

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146 D76803

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Irene Fredericka Connelly

(a) RESIDENCE No. 2137 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas. Henry Connelly

6 DATE OF BIRTH (month, day, and year) June 26, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER Thos. Joyner

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Records (Address)

15 Filed JUN 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1923

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1923, to June 16, 1923, that I last saw h alive on June 16, 1923, and that death occurred, on the date stated above, at 10.30 P.m.

The CAUSE OF DEATH* was as follows:

Septicaemia (Hemolytic)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Miscarriage (Spontaneous)

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Blood Exam. & Lab.

(Signed) Frank C. Kearney, M. D.

June 18, 1923 (Address) 1300 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL June 19 1923

20 UNDERTAKER Harry H. Witzke — ADDRESS 1531 W. Lombard

N. B.—Write plainly. Information should be carefully supplied. Answers to questions may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D76804

Registered No.....

1-PLACE OF DEATH D76804

City of BALTIMORE: (No. Municipal Hospital. St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dennis Cullen

(a) Residence No. Bay View Asylum St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1864

7-AGE. 58 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Ireland

PARENTS.

10-NAME OF FATHER John Cullen

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER, Mary Coulter

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Municipal Hospital Records

(Address)

15- Filed JUN 18 1923 192 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 13, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 13 19 23 to June 13 19 23

that I last saw h. im alive on June 12 19 23

and that death occurred, on the date stated above, at 3:30 A. M

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 1 (intery) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Terminal) (Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? C. M. Shipley M. D

(Signed) 6-13-19 23 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. National Cemetery DATE OF BURIAL. 6/18 1923

20-UNDERTAKER. Sol Levinson Bro ADDRESS 127 E Balto St

should be carefully supplied, as it may be properly classified. Examine in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

C-1014223

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76805 X 31 D76805

D76805

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH U.S. Veterans' Hospital #56,

CITY OF BALTIMORE: (No. Ft. McHenry, Md. ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward R. JONES

(a) RESIDENCE NO. Box 105, South Charleston, Kanawha Co. W. Va.
(Usual place of abode) ST., WARD
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of -

6 DATE OF BIRTH (month, day, and year) -

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or.....min.
	26	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer ----

9 BIRTHPLACE (city or town)
(State or country) W. Va.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Hospital Records
(Address) Ft. McHenry, Md.

15 JUN 18 1923 ROBERT R. KRANTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 30, 1922 to June 17 1923, that I last saw him alive on June 17 1923, and that death occurred, on the date stated above, at 11:45 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis active

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculosis active

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? positive sputum

(Signed) C. H. McNemar, P. A. Surg. R. M. D.

6-18-1923 (Address) Ft. McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Scott Depot West Va

DATE OF BURIAL 6/18 1923

20 UNDERTAKER Sol Levinson & Bro. ADDRESS 1121 E. Balto

N. B.—WRITE plainly and be careful and accurate. Every question should be carefully answered. Information should be carefully supplied. Nothing should be omitted that may be properly classified under the head of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Mary J Johnson

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76806 CERTIFICATE OF DEATH. Registered No. C..... D76806

1-PLACE OF DEATH

City of BALTIMORE: (No. 1604 Presstman St. 15 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Johnson 45

(Residence in Baltimore: No. 1604 Presstman St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colord	Married

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1..... (Year)

7-AGE. ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): Housekeeper

9-BIRTHPLACE. (State or Country). Charles Co Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geny Dotson

(Address) 6004 Presstman St

JUN 18 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 17 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry I find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Jaundice
Disease of Heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Morris Taylor M. D.
(Coroner)

1923 (Address) 202 Rd Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cemetery DATE OF BURIAL. June 19 1923

20-UNDERTAKER. Dir Robert F Kaufmann ADDRESS 1723

N. B.—Every item of information should be given, so that it may be plainly understood, and should be stated in plain terms, so that it may be properly understood by the general reader. In stating CAUSE OF DEATH in plain terms, so that it may be properly understood by the general reader. In stating CAUSE OF DEATH in plain terms, so that it may be properly understood by the general reader. See instructions on back of certificate. is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D76807

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D76807

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 514 Sanford Pl ST., 14 WARD)

2-FULL NAME Colman Cohn

(a) RESIDENCE NO. 514 Sanford Pl ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant 6

(b) General nature of industry, business, or establishment in which employed (or employer) Clothe 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Roumania

PARENTS

10 NAME OF FATHER Isaac Isidor Cohn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Roumania

12 MAIDEN NAME OF MOTHER Rosa Kuns

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Emanuel Cohen (Address) 514 Sanford

15 Filed JUN 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to June 1, 1923, that I last saw h alive on June 1, 1923, and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Coma

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema a Coma (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? clinical findings.

(Signed) Michael A. Abrams, M. D.

June 1 1923 (Address) 2360 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ohel Shalom Cem DATE OF BURIAL 6/19 1923

20 UNDERTAKER J. Ahrens Co 1611 Madison ADDRESS

N. B.—WRITE ... should be carefully supplied. ... mation should be properly ... so that it may ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76808 CERTIFICATE OF DEATH. 101-001 D76808

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Joseph's Hosp ST., (WARD) 5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Kerney

(a) RESIDENCE NO. 340 Forrest ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 500

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

JUN 18 1923 Burial Permit Clerk

THE MORGUE.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1923. to June 15, 1923. that I last saw h[illegible] alive on June 14. 1923., and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Krager M. D.

. 19 (Address) St. Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

ADDRESS

20 UNDERTAKER

JUN 18 1923

Commissioner Health.

N. B.—Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16-001 ✓ D76809

D76809 CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Hirsch

(a) RESIDENCE NO. University Hospital ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or 10 min.
			0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Hirsch

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Florence Strote

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mother
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 18 1923 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1923, to June 16, 1923, that I last saw h[illegible] alive on June 16, 1923, and that death occurred, on the date stated above, at 2:00 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar
(37 hrs)

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY
(Secondary) (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. Norwood Wilson, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL .....

DATE OF BURIAL .....

20 UNDERTAKER .....

ADDRESS .....

JUN 18 1923

N. B.—Write plainly. Every question should be carefully answered. Remember that it may be properly examined in court. Information should be carefully supplied. Remember that it may be properly examined in court. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76810 CERTIFICATE OF DEATH. 162 D76810

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Carter

(a) RESIDENCE NO. University Hospital ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14, 1923

7 AGE Years Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Earl Watson

11 BIRTHPLACE OF FATHER (city or town) Harmon
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sue Carter

13 BIRTHPLACE OF MOTHER (city or town) Glenburnie
(State or country) Maryland

14 Informant Mother
(Address)

15 Filed JUN 18 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1923

17

I HEREBY CERTIFY, That I attended deceased from June 14, 1923 to June 14, 1923.

that I last saw her alive on June 14, 1923

and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis
(38 hrs)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Maternal Eclampsia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Maxwell Wilson M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JUN 18 1923

N. B. While information should be carefully supplied, it may be properly changed, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

D76811

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76811

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 2306 E Lafayette Ave (St.) 8 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F Ohlendorf.

(a) RESIDENCE NO. 2306 E Lafayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feby 15th 1843.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER John Ashbach

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Joseph B Waltrode.
(Address) 2306 E Lafayette ave

15 Burial Permit Issued

Registrar

JUN 18 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1923, to June 15, 1923.

that I last saw her alive on June 13, 1923

and that death occurred, on the date stated above, at 11P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis,

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank C. Ellenbe M. D.

16, 1923 (Address) 9 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL June 19 1923

20 UNDERTAKER Robt F Turner Inc 7 Broadway

ADDRESS 1442

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be readily understood. TION is very important. See instructions on back of certificates.

ROBERT F. BARTLSON

Spec.—1-19-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76812

D76812

CERTIFICATE OF DEATH.

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Hospital ST., No WARD)

2-FULL NAME Franklin P. Ijams

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina Ijams

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or.....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) B & O (Retired)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER William Ijams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant William T. Ijams (Address) 409 S. Payson St.

15 Filed Jan 18 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1923

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1923, to June 15, 1923, that I last saw h... alive on June 15, 1923, and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Senile Dementia

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Goldsmith, M. D.

Jan 16 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Jan 19 1923

20 UNDERTAKER Jos Block — ADDRESS 1003 W Balto

UN 181923

mation should be carefully copied, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76813

CERTIFICATE OF DEATH.

100-001

D76813

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 812 S. Eutaw St. ST., 21 WARD)

2-FULL NAME Earl Horid. C.

(a) RESIDENCE NO. 812 S. Eutaw St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) April 2nd. 1922.

7 AGE	Years	Months	Days	If LESS than 1 day....hrs. or....min.
	1	2	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Lewis Norway. C.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania.

12 MAIDEN NAME OF MOTHER Emma Horid. C.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Louise Horid. C. (grandmother)
(Address) 812 S. Eutaw St.

Robert P. Harrison,

Filed JUN 18 1923, 192 Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15th. 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.
mal nutrition.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner.)

June 16th 23 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery DATE OF BURIAL June 9 1923

20 UNDERTAKER Wm. Geo. H. Hofer ADDRESS 406 Conway st

CAUSE OF DEATH in plain terms, so that no other cause can be substituted. See instructions on back of certificate. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76814

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76814

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1002 E. Eutaw St.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Smith

(a) RESIDENCE. No. 1002 E. Eutaw ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maggie Smith

6 DATE OF BIRTH (month, day, and year) Unknown 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57 yrs.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Co., Md.

PARENTS

10 NAME OF FATHER: Ashby Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co. Md.

12 MAIDEN NAME OF MOTHER: Maria Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co. Md.

14 Informant: Maggie Hutchins (Address) 1002 E. Eutaw St.

15 Filed ..... 19 Robert P. Harris Registrar

JUN 18 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1923

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1923, to June 16, 1923, that I last saw h[illegible] on June 16, 1923, and that death occurred, on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebro Pleuritis
Probably Tuberculous

About (duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. L. Shelton, M. D.

(Address) 203 W. Hamburg St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sharp St Cem Calvert Co Md	June 19 1923

UNDERTAKER: Jas Dent Hooper ADDRESS 40 N. Penna

mation should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76815

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76815

CERTIFICATE OF DEATH.

14 90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Frederick

(a) Residence No. 1624 Division St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1852

7-AGE. 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Frederick, Md.

PARENTS

10-NAME OF FATHER. Philip Rodroff

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Frederick, Md.

12-MAIDEN NAME OF MOTHER. Elizabeth McCann

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Frederick, Md.

14- (Informant) Municipal Hospital Records

(Address)

15- Filed 1923 Robert P. Harrison Registrar.

Burial Permit Clerk.

N 18 1923

Should be carefully written in plain terms, so that it may be properly classified. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 17, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 12 1923 to June 17 1923

that I last saw h...er alive on June 16 1923

and that death occurred, on the date stated above, at 4:00 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Myocardial degeneration

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. 1 mos. (Estimated) ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) N. Fr Smith M. D.

6-18-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 19 1923
20-UNDERTAKER. Geo I C Gibson	ADDRESS 573 Lanvale st

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76816

D76816

CERTIFICATE OF DEATH.

113

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4602 O Donnal ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Doris Lynch

(a) RESIDENCE. NO..... 4602 O Donnal ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 5 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Howard M Lynch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bath

12 MAIDEN NAME OF MOTHER Oda May Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bath

14 Informant Howard M Lynch
(Address) 4602 O Donnal St

15 Filed JUN 18 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1923

17 I HEREBY CERTIFY, That I attended deceased from June 16 1923 to June 17 1923

that I last saw her alive on June 17 1923

and that death occurred, on the date stated above, at 5-2 m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Frederick W Herrmann M.D.

6-18-23 (Address) 1914 E. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL June 19 1923

20 UNDERTAKER Wendell Dyffel & Son — ADDRESS 378 N

CAUTION is very important. See instructions on back.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D76817 D76817

CERTIFICATE OF DEATH. 159-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Cherry Hill. Westport. ST., 25 WARD)

2-FULL NAME Raymond Allen.(C).

(a) RESIDENCE NO. Cherry Hill. ST., Westport. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) April 16, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	----	2	1.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Allen.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Gertrude Boone.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md.

14 Informant Gertrude Boone.(C) mother
(Address) Cherry Hill, Westport.

15 Filed JUN 18 1923, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency-
Congenital.
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt, M. D.
(Coroner) June 18, 1923 (Address) 1019 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 6-19-1923

20 UNDERTAKER Daniel Easton

ADDRESS 916 Gay ave

CAUSE OF DEATH to be plain terms, See instructions on back of certificate. TION is very important.

D76818 HEALTH DEPARTMENT—CITY OF BALTIMORE D76818

D76818 CERTIFICATE OF DEATH. 74-001 Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. Fenno, Ed. Pitcher St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... John Mc Cormick

(Residence in Baltimore: No. 1608 Division St. St.; yrs. 60 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1853 (Year)

7-AGE: 70 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country): Balto. Co. Md.

PARENTS.

10-NAME OF FATHER, John Mc. Cormick

11-BIRTHPLACE OF FATHER, (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER, Mary Scott

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. McCormick

(Address) 1608 Division St.

15- Filed JUN 18 1923 192.... Robert P. Harrison, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or Inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

..... (Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D. (Coroner)

June 17, 192.... (Address) 2302 Eutaw Pl.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Cathedral Cem. DATE OF BURIAL: June 19 1923

20-UNDERTAKER: J. C. Wiedefeld ADDRESS 914 Fremont Ave.

Every item of information must be given in plain terms, so that it may be possible to state CAUSE OF DEATH in plain terms, so that it may be possible to state CAUSE OF DEATH in plain terms, so that it may be possible to state CAUSE OF DEATH

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76819

CERTIFICATE OF DEATH.

74-001

D76819

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Phillips

(a) RESIDENCE NO. 2054 Bank ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

may be properly classified, and
back of certificates.

mation should be carefully supplied, so that it
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ —

6 DATE OF BIRTH (month, day, and year) May 30th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Richard Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Nancy Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Annie Hammer (sister)

(Address) 2054 Bank St.

15 JUN 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16th 1923

17 I HEREBY CERTIFY, That I attended deceased from 6-13-23, 19 , to 6-16-23, 19 ,

that I last saw him alive on June 16th , 1923,

and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia -

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical Examination, Clinical History.

(Signed) Geo B Fuller, M. D.

(Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cemetery — DATE OF BURIAL: June 20th 1923

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 S. Mosher St

Cor.—1-12-23—M&T—100 Blks.

D76820

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D76820

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Druid Hill Ave. ST., 14 WARD)

2-FULL NAME Baby Cockrell

(a) RESIDENCE NO 1704 Druid Hill Ave. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Jos Cockrell

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Myrtle Barnes

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Jos Cockrell
(Address) 1704 Druid Hill Ave

15 JUN 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17. 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

gastro-enteritis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) no history

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

..... 17, 1923 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon Cem.

DATE OF BURIAL June 18 1923

20 UNDERTAKER Samuel L Hensley

ADDRESS [illegible]

TION is very important. See instructions on back

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76821

CERTIFICATE OF DEATH.

D76821

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. Women H Mt Winans ST.; 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian M Scott

(Residence in Baltimore: No. women St Mt Winans St.; Life yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, Colrd

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June (Month) 30 (Day), 1900 (Year)

7-AGE, 22 yrs. 11 mos. 18 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9-BIRTHPLACE, (State or Country), Mt Winans

PARENTS.

10-NAME OF FATHER, Jerome D Jones

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Celestine L Morton

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Celestine L Morton

(Address) Mt Winans

15-

Filed....., 191.... ROBERT R. KRAUTER, Registrar.

JUN 19 1923 Burial Permit Issued

N.B. CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 6 (Month) 16 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 26 1923, to June 16 1923, that I saw her alive on June 16 1923, and that death occurred, on the date stated above, at 1125 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

..... (Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

..... (Duration).....yrs.....mos.....ds.

(Signed) Wm H Hall M. D.

6-19, 1923 (Address) Walbrook

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn Cem	6/19, 1923
20-UNDERTAKER	ADDRESS
Samuel Wensley	528 Eutaw St

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76822

CERTIFICATE OF DEATH.

9° D76822

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1340 W. Mount ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Malinda Little,

(a) RESIDENCE NO. 1340 W. Mount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ WIFE of George W. Little

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. County, Md.

PARENTS

10 NAME OF FATHER Saml. Schuyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balto. Co., Md.

14 Informant Clara J. Hall

(Address) 1340 W. Mount St.

15 JUN 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1923, to June 16, 1923, that I last saw her alive on June 16, 1923, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) 1 yrs. 4 mos ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Exam.

(Signed) John D. Quinn, M. D.

1923 (Address) 1507 N. Dulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL June 19 1923

20 UNDERTAKER Sam'l. W. Thacker

ADDRESS 1700 Madison

...mation should be carefully supplied, so that it may be properly ...
CAUSE OF DEATH in plain terms, so that it ...
TION is very important. See instructions on ... of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76823

D76823

CERTIFICATE OF DEATH.

185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 E. 28th ST., 9 WARD)

2-FULL NAME Leonard David Jenkins Jr.

(a) RESIDENCE NO. 1622 E. 28th ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
		11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER L. D. Jenkins Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Theo Keiner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Leonard David Jenkins (Address) 622 E. 28th St.

15 JUN 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1923

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1923 to June 18, 1923

that I last saw him alive on June 18, 1923

and that death occurred, on the date stated above, at 7 40 A. m.

The CAUSE OF DEATH* was as follows:

Epithysial Separation of Lower E.P. of R. Femur (Fracture)

(duration) — yrs. — mos. 22 ds.

CONTRIBUTORY (Secondary) Acute Lobar Pneumonia

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-Ray of Rt. Leg

(Signed) L. Rehn M. D.

(Address) 3101 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL June 25 1923

20 UNDERTAKER H. Vander & Sons — ADDRESS 1710 Fleet St.

N. B.—Answers should be carefully supplied. Information should be properly classified, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76824

CERTIFICATE OF DEATH.

D76824

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Homewood Hospital St., 1216 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number).

2-FULL NAME William Oliver Saville

(a) Residence No. 1101-W-Lanvale St., 16 Ward Resident

(Usual place of abode) (If non-resident give City, Town and State)

Length of residence in city or town where death occurred 83 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 83 yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Sarah A. Saville

6-DATE OF BIRTH (month, day and year) About 1840

7-AGE. 83 yrs. ? mos. ? ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired U.S.

(b) General nature of Industry, business, or establishment in which employed (or employer) Government Employee

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER John Oliver Saville

11-BIRTHPLACE OF FATHER (city or town) Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Amelia Sisco

13-BIRTHPLACE OF MOTHER (city or town) Baltimore (State or Country), Maryland

14- (Informant) Mr. Robt. S. Downes, Son in Law

(Address) Washington D.C.

15- JUN 19 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June-17-1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 23 1922 to June 17 1923

that I last saw h[illegible]ive on June 17 1923

and that death occurred, on the date stated above, at 2.18 P.M.

The CAUSE OF DEATH was as follows:

Diabetes

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cause

(Duration) yrs. mos.

18-Where was disease contracted if not at place of death? 1100 Wdumont

Did an operation precede death? None Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. & Laboratory

(Signed) M. D.

6/17, 1923 (Address) Homewood Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL, June 19 1923

20-UNDERTAKER STUART & MOWEN COMPANY

ADDRESS 108 W. NORTH AVE.

(WILLIAM F. [illegible])

Blood to be entered in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec- 12-23-21—E.B.F.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1C 129 D76825

D76825

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2501 Maryland Av St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Ramsey Etchberger

(a) Residence No. 2501 Maryland Av St., 12 Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 7 mos. 18 ds. How long in U. S., if of foreign birth? 76 yrs. 7 mos. 18 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Jas. S. Etchberger

6-DATE OF BIRTH (month, day and year) Nov-1-1846

7-AGE. 76 yrs. 7 mos. 18 ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of Industry, business, or establishment in which employed (or employer)..... none

(c) Name of employer..... none

9-BIRTHPLACE (city or town)..... Baltimore

(State or Country)..... Maryland

PARENTS.

10-NAME OF FATHER Chas. Henry Cooksey

11-BIRTHPLACE OF FATHER (city or town)..... Virginia

(State or Country)

12-MAIDEN NAME OF MOTHER Mary Granville Neilson

13-BIRTHPLACE OF MOTHER (city or town) St Mary Co.

(State or Country) Maryland

14-(Informant) Miss Mary F. Etchberger (daughter)

(Address) 2501 Maryland Ave

15-Filed JUN 19 1923 ROBERT R. KRAETER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 18 1923

17- I HEREBY CERTIFY, That I attended deceased from August 8 1919 to June 18 1923.

That I last saw h.r alive on June 17 1923.

and that death occurred, on the date stated above, at 6.30A m.

The CAUSE OF DEATH* was as follows:

Cardio nephropathy

(primary nephritis)

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. M. Shipley M. D.

June 18 1923 (Address) 24 E. Mt. Vernon Pl.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Cemetery DATE OF BURIAL, June 21 1923

20-UNDERTAKER Stuart & Mowen Company ADDRESS 108 W. North Ave

(William F. Mowen, Manager)

Should be carefully written, so that it may be properly classified in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76826

CERTIFICATE OF DEATH.

89 D76826

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Esplanade Apts. ST. 5 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther Straus Kaufman

(a) RESIDENCE NO. Esplanade Apts. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jonas Kaufman

6 DATE OF BIRTH (month, day, and year) Oct. 13, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	75	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bavaria

PARENTS

10 NAME OF FATHER Joshua Straus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Babette Dessauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria

14 Informant Mrs. B. Husberg (Address) Esplanade Apts 3B.

15 Filed JUN 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/18/ 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1922 to June 18 1923, that I last saw h- alive on June 18 1923, and that death occurred, on the date stated above, at 39 m.

The CAUSE OF DEATH* was as follows:

arteri-sclerosis +

(coronary sclerosis)

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina pectoris

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) I Frederick Lee M. D.

, 19 (Address) 2045 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem.	6/20/ 1923
20 UNDERTAKER	ADDRESS
Laird Sondheim	115 W. Mt. Royal Ave

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76827

CERTIFICATE OF DEATH.

31 D76827

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital St., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olive Jackson

(a) RESIDENCE NO. 523 Oxford st. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress

(b) General nature of industry, business, or establishment in which employed (or employer) 670

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Chas. Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Martha Toblin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address) M.T.H.

15 Filed JUN 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1923, to June 16, 1923.

that I last saw her alive on June 16, 1923.

and that death occurred, on the date stated above, at 11.20 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Sp. in sputum, X-ray

(Signed) Frances L. Badgley M. D.

6-16-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W.L. Rutter DATE OF BURIAL June 19, 23

20 UNDERTAKER V. Lewis ADDRESS 1203 Druid

N. B.—mation should be carefully ... so that it may be properly ... CAUSE OF DEATH in plain terms. ... TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76828

D76828

CERTIFICATE OF DEATH.

101-001

REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 911 Carrollton Ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Ford
(Residence in Baltimore: No. 911 Carrollton Ave St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. Not known, (Month) (Day) 1894 (Year)

7-AGE. 29 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Market dealer
(b) General nature of industry, business, or establishment in which employed (or employer): Washington Market

9-BIRTHPLACE, (State or Country): Shady Side Md.

PARENTS.

10-NAME OF FATHER. Arthur Knox

11-BIRTHPLACE OF FATHER (State or Country). Va

12-MAIDEN NAME OF MOTHER Mary Dreenon

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ida Knox
(Address) 911 N. Carrollton Ave

15- FILED JUN 19 1923 ROBERT R. KRAETER Burial Permit Clerk.

N.B.—DEATH in plain terms, so that it may be CAUSE OF DEATH important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 17 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15 1923, to June 17 1923, that I saw him alive on June 16 1923, and that death occurred, on the date stated above, at 8.30 a m.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) 3 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) John C. Stewart M. D.
6-19, 1923 (Address) 701 W. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Shady Side Md. DATE OF BURIAL. June 20, 1923

20-UNDERTAKER Ed N. Dennis ADDRESS 1303 Greenmount

Broderick

D76829

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76829

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home Infirmary St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernst W. Broderick

(Residence in Baltimore: No. 2623 Hilton St. St., 4 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	single

6-DATE OF BIRTH. Feb. 10/1900 (Month) (Day) (Year)

7-AGE. 23 yrs. 4 mos. 6 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Operator Elec.
(b) General nature of Industry, business, or establishment in which employed (or employer): Crane- Cottman Co.

9-BIRTHPLACE. (State or Country). Port Mead Fla.

PARENTS.

10-NAME OF FATHER. George L. Broderick

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Ethel Gross

13-BIRTHPLACE OF MOTHER, (State or Country). England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Norman T. Gerard

(Address) 2623 Hilton St.

15- JUN 19 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 16/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull-left frontal, temp. & sphenoidal regions.
(accidental- over)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J S Pace M. D.
(Coroner)

6/18/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Woodlawn. DATE OF BURIAL. June 19 1923

20-UNDERTAKER. E. A. Mudefeld ADDRESS 501 E 22 St

N. B.—Every question must be answered. If the exact information cannot be given, state CAUSE OF DEATH in plain terms, so that the nature of the disease may be understood. This is very important. See instructions on back of certificate.

D76830

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76830

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 13 N. Caroline St. 6 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Horace Allen

(Residence in Baltimore: No. 13 N. Carlline St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	black	Married

6-DATE OF BIRTH. unknown (Month) (Day) 1852 (Year)

7-AGE. 51 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: boot black
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER. (State or Country). "

12-MAIDEN NAME OF MOTHER. "

13-BIRTHPLACE OF MOTHER. (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Isaac Griffin

(Address) 10 N. durham St.

15-

JUN 19 1923

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 17/23 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insuffiency (Probab.)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Probable Nephritis

(Duration) yrs. mos. ds.

(Signed) J S Wallis M. D. (Coroner.)

6/18/23 192.... (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Ashb. Cemetery June 19th 1923

20-UNDERTAKER. ADDRESS
Miller Louis 714 N Eden

N. B.—Every CAUSE OF DEATH in plain terms, so that it can be understood by all. Be sure to state CAUSE OF DEATH in plain terms, so that it can be understood by all. See instructions on back of certificate. is very important.

Spec.—1-10-21—M&T—1500 Bks.

D76831

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76831

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 937 W. Lexington ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Collins

(a) RESIDENCE NO. 937 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	47	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Tinner 84

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Collins

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Hines

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs Maria A. Hodges

(Address) 937 W Lexington St

Filed JUN 19 1923 ROBERT R. KRAUTH, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/17/23

17

I HEREBY CERTIFY, That I attended deceased from 8/23/22, 19 , to 6/17/23, 19 ,

that I last saw h— alive on 6/16/23, 19 ,

and that death occurred, on the date stated above, at 2 45 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Pulmonary Phthisis

(duration) Years 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? None .....

(Signed) Bernard F. Terry, M. D.

6/18/1923 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	June 20 1923
20 UNDERTAKER Geo. W. Smith & Co.	ADDRESS 1532 Hollins St

N. B.—mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76832 113 D76832

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Jamaica Hill & Carnegie Ave

CITY OF BALTIMORE. (No. Graceland Pk St., 10 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rita Kwiatkowski

(a) RESIDENCE NO. Jamaica Hill & Carnegie Ave ST., Graceland Park WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, ~~Married, Widowed, or Divorced, (write the word)~~ Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31, 1923

7 AGE Years Months Days If LESS than 1 day, ...hrs. or ....min.
~~19 days~~ ~~1923 May 31~~ 19 days

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md.

PARENTS

10 NAME OF FATHER Vincent Kwiatkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Jozefa Wisslowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Vicint Kwiatkowski
(Address) Carnigie ave Grassland Park

15 Filed JUN 19 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 17 1923 - Child brought to office 12 o'clock that I last saw h[im] alive on at 1 a.m. June 19/23 and that death occurred, ~~on the date stated above~~, at 1 2 30 A.m.

The CAUSE OF DEATH* was as follows: Child seems to have been sick several days Without Diarrhoea or Infantile (duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Insanition (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Arthur W Mansfield, M. D.

. 19 (Address) Colgate Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus. DATE OF BURIAL 6/20. 1923

20 UNDERTAKER M. J. Sadowski ADDRESS 705 S. Wm

N. B. ... mation should be carefully ... CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76833

CERTIFICATE OF DEATH.

11 D76833

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 721 Sterling St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Coleman

(Residence in Baltimore: No. 721 Sterling St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	col	single

6-DATE OF BIRTH. March 6 (Month) 96 (Day) 1896 (Year)

7-AGE. 27 yrs. 3 mos. 11 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: laborer
(b) General nature of industry, business, or establishment in which employed (or employer): D

9-BIRTHPLACE. (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Dennis Coleman

11-BIRTHPLACE OF FATHER. (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Berlinda Wise

13-BIRTHPLACE OF MOTHER. (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dennis Coleman

(Address) 721 Sterling St.

15- JUN 19 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 6/17/23 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Acute Indigestion

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) No other history

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. H. Faile M. D. (Coroner.)

6/18/23 192.... (Address) 505 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Laurel Cemetery — DATE OF BURIAL. June 19 1923

20-UNDERTAKER. Mrs. R. C. Elliott — ADDRESS 1227 Eutaw

N. B.—Every item of information must be given in plain terms, so that state CAUSE OF DEATH in plain terms, so that is very important. See instructions on back of certificate.

D76834 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 D76837

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. ~~Sarah Garner~~ 1804 Orleans St. St. 6 Ward)
2-FULL NAME Sarah Garner
(Residence in Baltimore: No. 1804 Orleans St. St.; yrs.... mos.... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female
4-COLOR OR RACE: col.
5-Single, Married, Widowed, or Divorced (write the word.)
6-DATE OF BIRTH: Sept 8/1886 (Month) (Day) (Year)
7-AGE: 37 yrs. 8 mos. 9 ds. If LESS than 1 day, ...hrs. or ....min.
8-OCCUPATION: (a) Trade, profession, or particular kind of work: house work (D)
(b) General nature of industry, business, or establishment in which employed (or employer): at home
9-BIRTHPLACE (State or Country): Balto Md.

PARENTS.
10-NAME OF FATHER: John Chase
11-BIRTHPLACE OF FATHER (State or Country): Md.
12-MAIDEN NAME OF MOTHER: Laura Delogies
13-BIRTHPLACE OF MOTHER (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Husband James Garner
(Address) 1804 Orleans

15- Filed JUN 19 1923 192.. ROBERT R. KRAUTER, Burial Permit Clerk.

N. B.—Every item of information must be given in plain terms, so that it may be understood. In stating CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate. is very important.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, 6/17/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Pulmonary Hemorrhage
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Probably T.B.
(Duration) mos. ds.

(Signed) J S H Paul M. D. (Coroner)
6/18/23 (Address) 5pl E.Noth Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Lorraine Cemetery DATE OF BURIAL: June 19 1923
20-UNDERTAKER: Mrs. R.G. Elliott ADDRESS Fishburn Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76835

D76835

CERTIFICATE OF DEATH.

15 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4005 Reisterstown ST., 15 WARD)

2-FULL NAME Robert Henry Markey

(a) RESIDENCE NO. 4005 Reisterstown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 11 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Markey

6 DATE OF BIRTH (month, day, and year) June 23 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer Ward & Leach

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER Wm H. Markey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Kline

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa.

14 Informant Mrs. Margaret E. Kline

(Address) 4005 Reisterstown

15 JUN 19 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17. 1923

17 I HEREBY CERTIFY, That I attended deceased from June 11 1923 to June 17 1923.

that I last saw him alive on June 17 1923.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

Chronic Pernchy. nephritis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Asthma Bronchitis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James D Ashurst, M. D.

1923 (Address) 401 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	June 20, 23

20 UNDERTAKER Wm J Pickney & Son

ADDRESS North Ave

B. Information should be carefully supplied, so that it may be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76836

CERTIFICATE OF DEATH.

161-001

D76836

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 N. Rose ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alma M. Rippel

(a) RESIDENCE NO. 202 N. Rose ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) —

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 10/23

7 AGE Years ..... Months ..... Days 9 If LESS than 1 day, hrs ..... or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER Walter Rippel

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country)

12 MAIDEN NAME OF MOTHER Ernestine Hasky

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.

(State or country)

14 Informant Walter Rippel

(Address) 202 N. Rose St.

15 JUN 19 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1923

17 I HEREBY CERTIFY, That I attended deceased from June 18th, 1923, to June 19th, 1923, that I last saw her alive on June 19th, 1923, and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Anaemia

CONTRIBUTORY (Secondary) (duration) Premature Birth 7 Month yrs. ..... mos. ..... da.

(duration) yrs. ..... mos. ..... da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah J. Russell, M. D.

, 19 (Address) 156 N. Dulaney

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL June 20 1923

20 UNDERTAKER Jos. J. Herr & Son ADDRESS 156 N. Luzerne

Information should be carefully supplied, so that it may be properly entered in plain terms, so that it may be properly entered in plain terms. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important

D76837 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76837

D76837

CERTIFICATE OF DEATH. 129

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 806 N. Lakewood Ave. St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John W. Tucker

(Residence in Baltimore: No. 805 N. Lakewood Ave. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	Married

6-DATE OF BIRTH. October 25/1856 (Month) (Day) 1 (Year)

7-AGE. 56 yrs. 7 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Samuel Tucker

11-BIRTHPLACE OF FATHER. (State or Country). unknown

12-MAIDEN NAME OF MOTHER. Catherine unknown

13-BIRTHPLACE OF MOTHER. (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Sarah Tucker wife

(Address) 806 N. Lakewood Ave.

15- Filed ..... 192 ..... Robert P. Harrison, Registrar.

BIRTH NO. 191923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 16/23 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremia-(Convulsions)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis (Duration) yrs. mos. ds.

(Signed) J S Mallon M. D. (Coroner.)

6/18/23 192.... (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cemetery DATE OF BURIAL. 6/20 1923

20-UNDERTAKER. E. J. Fanning & Son ADDRESS 2 Lafayette

B.—Every item of information should be carefully ... state CAUSE OF DEATH in plain terms, so that it may be properly ... is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76838

D76838

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2716 Wilkens Ave. ST., 70 WARD)

2-FULL NAME William Franklin Hayes.

(a) RESIDENCE NO. 2716 Wilkens Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Widower.

5a If married, widowed, or divorced HUSBAND of Laura V. Hayes. of the, late

6 DATE OF BIRTH (month, day, and year) July 4, 1840.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	82.	11.	15.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Railroad

(b) General nature of industry, business, or establishment in which employed (or employer) Conductor.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brunswick, Md.

PARENTS

10 NAME OF FATHER Dont Know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know.

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know.

14 Informant Mrs. Hubbard. (Address) 2716 Wilkens Ave.

15 Robert P. Harrison, Registrar

N 19 1923 .19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1923

17 I HEREBY CERTIFY, That I attended deceased from May 15 .1923. to June 19 .1923.

that I last saw him alive on June 18 .1923.

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Benj. F. Phillips M. D.

June 19 1923 (Address) 7929 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Louden Park Cemetery. DATE OF BURIAL: June, 21, 1923

20 UNDERTAKER: A. Howard Evans ADDRESS: 1428 S. Charles St.

...mation should be given in plain terms, so that it may be properly ... CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—8-24-14—M. & T.—2000 Blks.

D76839

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 74-00 D76839

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Elizabeth Cole.

(Residence in Baltimore: No. Laurel Md. St.; ....yrs., ...mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, ... Not Known ....., 1 .....
(Month) (Day) (Year)

7-AGE, 48 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... HW .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Not Known

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Not Known

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ..... Agnes Cole .....

(Address) ..... Laurel Md. .....

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk

JN 19 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 19, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 18 1923, to June 19 1923, that I saw h[illegible] alive on June 19 1923 and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

..... Hemoglazen .....

..... (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Uremic Poisoning

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) Geo. E. Shannon M. D.

June 19, 1923 (Address) Md Gen. Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 1 ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Laurel, Md.

Former or usual residence Laurel Md

19-PLACE OF BURIAL OR REMOVAL, Laurel Md. DATE OF BURIAL, 6/19/23, 1923

20-UNDERTAKER E & B Hall ADDRESS 1 E 1[illegible]

CAUSE OF DEATH in plain terms, so that its nature is important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D76840

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76840

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1916 Hanover ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Hamlein

(a) RESIDENCE NO. 1916 Hanover ST., 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Hamlein

6 DATE OF BIRTH (month, day, and year) Aug 22 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or estsblishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER John Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Dove

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Hamlein

(Address) 1916 Hanover St.

15 Filed JUN 19 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1923

17 I HEREBY CERTIFY, That I attended deceased from June ..., 1922, to June 19, 1923

that I last saw him alive on June 18, 1923

and that death occurred, on the date stated above, at 12-30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

Duration 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. P. Campbell M. D.

1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL June 21 1923

20 UNDERTAKER C Schlosman Sons

ADDRESS 1039 Hanover St

...mation should be carefully supplied, so that it may be ...
CAUSE OF DEATH in plain terms, so that it may be properly ...
TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D76841

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76841

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Patapsco ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph Ambach

(a) RESIDENCE NO. 1210 Patapsco ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Ambach

6 DATE OF BIRTH (month, day, and year) Dec 8th 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Ambach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Marie Ambach (Address) 1213 Patapsco St

15 Filed Robert P. Harrison, Registrar

JUN 19 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan-20, 1923, to June 17, 1923, that I last saw him alive on June 16, 1923, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Senile Myocarditis with decompensation ascites

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? none

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wesley Cole, M. D.

6/18, 1923 (Address) 220 Harrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	June 20 1923
20 UNDERTAKER E Schumacher Son	ADDRESS 1307 Pennsylvania Ave

N. B. Information should be carefully supplied, so that it may be properly transcribed. CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76842 118-001 D76842

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 Aisquith ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Martino

(Residence in Baltimore: No. 1037 Aisquith St. 64 yrs., 8 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Married

6-DATE OF BIRTH, Oct 2, 1855 (Month) (Day) (Year)

7-AGE, 64 yrs. 7 mos. 17 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Painter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Antonio F. Martino

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Julia A Green

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lorenzo Martino

(Address) 1037 Aisquith St.

15-

JUN 19 1923

Robert P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 18, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 18 1923, to June 18 1923, that I saw h[illegible] alive on June 18 1923, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) 2 yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Thrombosis

(Duration) 1 yrs. 10 mos. ....ds.

(Signed) Raymond C. Gibbons M. D.

June 2, 1923 (Address) Lakeland

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Loudon Park Cem. DATE OF BURIAL. June 22, 1923.

20-UNDERTAKER J. Stephenson Sons ADDRESS 1034 Hanover St

Every CAUSE OF DEATH in plain terms, as much as possible important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76843

CERTIFICATE OF DEATH.

74-001 D76843

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hospital ST.; 28 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rev. Francis Tagg

(Residence in Baltimore: No. 4602 Belvidere ave St. 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, June (Month) 7 (Day), 1845 (Year)

7-AGE, 78 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Tagg.

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER, Mary Stouciffer

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Edgar Tagg

(Address) 4306 Belvidere Ave

15-

Filed ..... Robert P. Harrison, Registrar

JUN 19 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 18 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 1923, to June 18 1923, that I saw h[er] alive on June 18 1923, and that death occurred, on the date stated above, at 5.45 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... yrs. ..... mos. 7 ..... ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James Hubert Wilkerson M. D.

June 18, 1923 (Address) Md. General Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Confederate Md | DATE OF BURIAL, June 20 1923

20-UNDERTAKER John A Mitchell | ADDRESS 1201 W Fayette

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76844

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76844

CERTIFICATE OF DEATH.

Registered No. 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 1619 Argyle St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Ackerman

(a) Residence No. 1619 Argyle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph

6-DATE OF BIRTH (month, day and year) Aug 16 1853

7-AGE, 69 yrs. mos. ds.

If LESS than 1 day, hrs. or. mln.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Unk-Known

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unk-Known

12-MAIDEN NAME OF MOTHER, Unk-Known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unk-Known

14-

(Informant) Mrs Anna Edwards

(Address) 1619 Argyle St

15-

Filed JUN 20 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 18 1923

17- I HEREBY CERTIFY, That I attended deceased from June 1 1923 to June 18 1923

that I last saw her alive on June 18 1923

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(Duration) yrs. 10 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs & Symptoms

(Signed) D. Anne Krauter M. D.

, 19 (Address) 1506 N Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loraine DATE OF BURIAL, June 21 1923

20-UNDERTAKER, Wm Cook ADDRESS 332 E Fayette

In plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec—12-23-21—E.B R.S.—400 Bks.

D76845

HEALTH DEPARTMENT—CITY OF BALTIMORE

3M D76845

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2606 Riggs Ave St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Mary Viola Phelps

(a) Residence No... 2606 Riggs Ave St,.....Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or ~~Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 17/1899

7-AGE, 23 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work... at home

(b) General nature of industry, business, or establishment in which employed (or employer)...

(c) Name of employer...

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER Wm A Phelps

11-BIRTHPLACE OF FATHER (city or town) (State or Country). A a Co Md

12-MAIDEN NAME OF MOTHER Beulah Segar

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Md

14- (Informant) William A Phelps

(Address) 2606 Riggs Ave

15- Filed JUN 20 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 19/23

17- I HEREBY CERTIFY, That I attended deceased from Apr 1 1923, to June 18 1923

that I last saw h.. alive on June 18 23

and that death occurred, on the date stated above at 3:22 m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B. 3

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal T.B. 6 mos. ds.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Oliver Murray, M. D.

(Address) 1221 W. Lafayette Ave.

June 19 23

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL. Friendship A&C DATE OF BURIAL, June 21, 1923

20-UNDERTAKER. William Cook & Son E Balto

ADDRESS

In filling out this certificate, please write in plain terms, so that it may be properly understood. Read carefully the instructions on back of certificates.

AFFIDAVIT

Spec.—1-10-21—M&T—1500 Blks.

44067
D76846

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

69 D76846

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 22 WARD)

2-FULL NAME Emma May Todd

(a) RESIDENCE NO. 319 S. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Walter W. Todd

6 DATE OF BIRTH (month, day, and year) July 3-1892

7 AGE: Years 30; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W. 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER John Millett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Sarah Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 JUN 20 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17th 1923

17

I HEREBY CERTIFY, That I attended deceased from May 31st, 1923, to June 17th, 1923, that I last saw her alive on June 17th, 1923, and that death occurred, on the date stated above, at 9:20 P. m.

The CAUSE OF DEATH* was as follows:

Purpura Hemorrhagica

(duration) yrs. 3 mos. wks. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. 2 mos. wks. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas. R. Bunts, M. D.

6/20/1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: June 20 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E. Wath

mation should be ... CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of certificates.

KODAK SAFETY FILM

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D76847

100-001

D76847

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 3774 Monterey ST. 70 WARD)

2-FULL NAME Nicholas Joseph Merson

(a) RESIDENCE. NO. 3774 Monastery Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9 March 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Noble J. Merson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland County

12 MAIDEN NAME OF MOTHER Mc Diarmid Legg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Noble Merson

(Address) 3774 Monastery Ave

15 Filed . 19 JUN 20 1923

ROBERT R. KRANTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1923, to , 19 , that I last saw him alive on June 18, 1923, and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Ward C Greene, M. D.

. 19 (Address) 1013 Poplar Grove St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lauden Park	June 20 1923
20 UNDERTAKER	ADDRESS
Mr-Mrs A S Eisenbrandt	1737 W Pratt St

If any of information should be given in response to any of these inquiries, the space should be marked "None," with a line drawn through it. CAUSE OF DEATH in plain terms, so that it may be understood by the general public. See instructions on back of certificates. SECTION is very important.

D76848

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D76848

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 315 So. Chapel St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Herold

(Residence in Baltimore: No. 315 So. Chapel St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. March (Month) 6th (Day) 1878 (Year)

7-AGE. 45 yrs. 3 mos. 12 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Store Keeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Matthias Herold

11-BIRTHPLACE OF FATHER, (State or Country) Germany

12-MAIDEN NAME OF MOTHER. K. Hauptd

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Andrew Herold

(Address) 2411 E. Monument St

15- JUN 20 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 18th (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Ingram (Inquest, autopsy or inqutry.) thereon and from the evidence obtained by the Ingram (Inquest, autopsy or inquiry.) find that said deceased came to... his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

a few

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. C. McHorton M. D.
(Coroner.)

June 18 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Balto. Md

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer Cem.	June 20, 1923.

20-UNDERTAKER.	ADDRESS
Lilly and Zeiler	403 S. Wolfe St.

N. B.—Every item must be filled in, so that state CAUSE OF DEATH in plain terms, so that is very important. See instructions on back of certificate.

Merrill J. Johnson

D76849

D76849

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE, (No. Homewood Apts. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Merrill J. Johnson

(Residence in Baltimore: No. 2331 E. Hoffman St.; yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Aug 26th 1903
(Month) (Day) (Year)

7-AGE 19 yrs. 10 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cunning Maker
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE. (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Benjamin Johnston

11-BIRTHPLACE OF FATHER. (State or Country). Baltimore Md.

12-MAIDEN NAME OF MOTHER. Laura V. Smith

13-BIRTHPLACE OF MOTHER. (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Benjamin G. Johnson

(Address) 2331 E. Hoffman

15-

FILED JUN 20 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 17 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries from motor truss accident

(Duration) ..... yrs. ..... mos. (Over)

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

1923 (Address) 3532 Boyd Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Baltimore Cemetery DATE OF BURIAL. June 21 1923

20-UNDERTAKER. Robt L. Turnbull ADDRESS 1144 E Broadway

N. B.—Every item of this certificate should be carefully answered. In particular, state CAUSE OF DEATH in plain terms, so that it can be understood. Name of Hospital is very important. See instructions on back of certificate.

D76850

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-005 D76850

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4507 Liberty Heights St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... James Clay Gilbert

(Residence in Baltimore: No. Garrison & Hilton ..... St.; yrs. 38 mos. 6 ds. 4)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Dec. (Month) 14 (Day) 1884 (Year)

7-AGE.	If LESS than 1 day,
38 yrs. 6 mos. 4 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Lumber Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)..... Self

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, James T. Gilbert

11-BIRTHPLACE OF FATHER, (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER, Emma J. Kaufmann

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma J. Gilbert

(Address) 4507 Liberty Heights

JUN 20 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 18 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carbon monoxide gas accidental

1 hour (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) from asphyxiation

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

June 19, 1923 (Address) 2702 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Woodlawn DATE OF BURIAL. June 20 1923

20-UNDERTAKER. Chas. E. Crouch & Son ADDRESS Madison

N. B.—Every item of this certificate should be answered with the greatest care. Be sure to state CAUSE OF DEATH in plain terms, so that it can be understood by a layman. Every item is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76851

CERTIFICATE OF DEATH.

31 D76851

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 138 N. Bond ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annis Parker

(a) RESIDENCE. NO. 138 N. Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of James A. Parker

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Alex Gordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) James A. Parker 138 N. Bond St

15 Filed JUN 20 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1923, to June 17, 1923, that I last saw h[illegible] alive on June 17, 1923, and that death occurred, on the date stated above, at 9-15 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robt J Grum, M. D.

(Address) 126 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel cemetery	June 21 1923
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans

mation about the cause of death in plain terms, so that the CAUSE OF DEATH in plain terms, so that the CAUSE OF DEATH is very important. See instructions on back of certificate.

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D76852

CERTIFICATE OF DEATH.

D76852

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 734 N. Gay St. ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Adams Schafer

(a) RESIDENCE. NO. 734 N. Gay St ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 21-1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Restaurant keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pittsburg, Pa

PARENTS

10 NAME OF FATHER John Adams Schafer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Kate Andrega

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Wife Lorraine Schafer 734 N Gay St

15 Filed JUN 20 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 9 1923. to June 17 1923. that I last saw him alive on June 17 1923. and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Cause Broncho pneumonia)

(duration) — yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? ~

(Signed) B M Bengartt M. D.

6/18. 1923 Address) 3451 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	June 21 1923
20 UNDERTAKER	ADDRESS
Johannah Canoles	1004 Argyle

mation should be written in ink, in plain terms, so that it may be understood by the laymen who make use of certificates. CAUSE OF DEATH in plain terms, so that it may be understood by the laymen who make use of certificates. TION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76853

CERTIFICATE OF DEATH.

D76853

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1726 Byrd St. ST., 26 WARD)

2-FULL NAME Mary Emma Spurry

(a) RESIDENCE NO. 1726 Byrd St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Spurry

6 DATE OF BIRTH (month, day, and year) May 17 - 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

037

9 BIRTHPLACE (city or town) (State or country): Talbott Co. Md.

PARENTS

10 NAME OF FATHER: W. H. Marshall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. Miles (Address) 1715 Byrd St.

15 JUN 20 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from April 5th 1923 to June 18th 1923.

that I last saw her alive on June 15th 1923.

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans

(duration) 2 yrs. 2 mos 13 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Diagnosis

(Signed) Harry Kerbel M.D.

6/20 1923 (Address) 1224 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery

DATE OF BURIAL 6/20 1923

20 UNDERTAKER: L. Frew McCully

ADDRESS 1308 Fort

mation should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE. See instructions on back of certificates. TION is very important.

D76854

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D76854

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns HOPKINS HOSPITAL St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Avedis Brown

(Residence in Baltimore: No. 811 West Fayette St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	

6-DATE OF BIRTH. June 1st, 1923. 1
(Month) (Day) (Year)

7-AGE. ....yrs. ....mos. 18 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) none

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Floyd Brown

11-BIRTHPLACE OF FATHER. (State or Country). Louisania

12-MAIDEN NAME OF MOTHER. Mary Williams

13-BIRTHPLACE OF MOTHER. (State or Country). Kansas

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Floyd Brown

(Address) 811 W. Fayette St.

15- JUN 20 1923 ROBERT R. KRAUTER Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 18/23, 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Erysilelas- peritonitis (strep)

autopsy at hospital

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [signature] M. D.
(Coroner.)

6/20/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Olivet Cem DATE OF BURIAL. June 20 1923

20-UNDERTAKER. H M Rowton ADDRESS 230 N Gay

N. B.—Every item must be answered, so far as possible, and the physician should state CAUSE OF DEATH in plain terms, so that it may be understood by the laity. This is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D76855

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76855

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. 5 ST., WARD)

REGISTERED NO. 74-002

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Neikrug

(a) RESIDENCE No. 210 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Agent

(b) General nature of industry, business, or establishment in which employed (or employer) Real Estate

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER David Neikrug

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1439 E. Balto. St.

15 JUN 20 1923 ROBERT R. KRAUER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1923, to June 19, 1923, that I last saw him alive on June 19, 1923 and that death occurred, on the date stated above, at 3.06 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (terminal)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Cerebral thrombosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Isidor J. Fry, M. D.

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL June 20th 1923

20 UNDERTAKER Jack Levin — ADDRESS 1439 E. Balto

N. B.—Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76856

CERTIFICATE OF DEATH.

47 D76856

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 600 Caloulton Rd. ST. 16 WARD)

2-FULL NAME Martha Ann Hartley. (Hartley)

(a) RESIDENCE. NO. 600 Caloulton Rd ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Allen Hartley.

6 DATE OF BIRTH (month, day, and year) July 12 83.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
~~70~~	39	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) Housekeeping

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Easton Md.

PARENTS

10 NAME OF FATHER Wm Henry Hunton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Campbells Md.

12 MAIDEN NAME OF MOTHER Mary Jane Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Campbells Md.

14 Informant James A. Hartley (Address) 600 Caloulton Rd

15 Filed JUN 20 1923 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 15 22, 19..., to June 19, 19 23,
that I last saw h-- alive on June 19, 19 23,
and that death occurred, on the date stated above, at 4 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast
Left.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Abscess Rt. Breast

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Easton Md.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) T. Wallace Lee M. D.

June 19 1923 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Easton Md.	6/22/23
20 UNDERTAKER	ADDRESS
Jno C. Mitchell	201 N Fayette

CAUSE OF DEATH in plain terms, so that a Physician can understand it. Abbreviations or terms not generally understood will not be accepted. Read carefully the instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76857

CERTIFICATE OF DEATH.

129 D76857

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 Leadenhall ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Wilson

(Residence in Baltimore: No. 1017 Leadenhall St.: 46 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Colored

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED~~, (Write the word.) Single

6-DATE OF BIRTH, ..., 1866
(Month) (Day) (Year)

7-AGE, 57 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore city

PARENTS.

10-NAME OF FATHER, arther Wilson

11-BIRTHPLACE OF FATHER (State or Country), md

12-MAIDEN NAME OF MOTHER Jane Smith

13-BIRTHPLACE OF MOTHER (State or Country), md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) hattie Washington

(Address) 1017 Leadenhall st

15. JUN 20 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit

N. B.—Every item of DEATH in plain terms, so that it may be understood. CAUSE OF DEATH important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 18, 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1923, to June 18 1923, that I saw h[illegible] alive on June 17 1923, and that death occurred, on the date stated above, at 6 [illegible] m.

The CAUSE OF DEATH* was as follows:

Or. Pancreatic Neoplasm

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) H. H. Ward M. D.

6/19, 1923 (Address) 2005 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, mt auburn Cemetery

DATE OF BURIAL, June 20, 1923.

20-UNDERTAKER Taddrin

ADDRESS 1027 Druidhill ave

Spec.—1-10-21—M&T—1500 Bks.

D76858

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D76858

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 N. Patterson Parkway ST., WARD)

2-FULL NAME Cornelius H. Shandleffer

(a) RESIDENCE NO. 1319 N. Patterson Park ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louisa G.

6 DATE OF BIRTH (month, day, and year): July 11, 1855

7 AGE — Years: 67 — Months: 11 — Days: 8 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED: Stonecutter

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Baltimore Co, Md.

PARENTS

10 NAME OF FATHER: Nicholas Shandleffer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Lowry

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Louis G. Shandleffer

(Address) 1319 Pat. Parkway

15 JUN 20 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 19 1923

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1923, to June 19, 1923.

that I last saw him alive on June 18, 1923.

and that death occurred, on the date stated above, at 7a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Physical Signs

(Signed) E. E. Fowler M. D.

June 19 1923 (Address) 1321 N. Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: June 23 1923

20 UNDERTAKER: Burbelent & Kirkler — ADDRESS: 1734 Eager

It may be printed on back of certificates.
mation should be given in plain terms, so that it may be understood. See instructions on back of certificates.
CAUSE OF DEATH is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76859

CERTIFICATE OF DEATH.

90 ✓ D76859

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Harlem Ave. ST., 16 WARD)

2-FULL NAME Jennie L. Templeton

(a) RESIDENCE NO. 906 Harlem Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 8, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	81	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Templeton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Maria L. Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant MARY T. TEMPLETON (Address) 906 Harlem Ave

15 Filed JUN 20 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUNE 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug, 1919, to June 19, 1923.

that I last saw her alive on June 19, 1923.

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis, mitral insufficiency

about 4 yrs. mos ds.
(duration)

CONTRIBUTORY (Secondary) Heart block

(duration) yrs. 1 mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no — usual tests

What test confirmed diagnosis?

(Signed) H. E Knipp, M. D.

JUN 19 1923

, 19 (Address) 1002 N. Fairmount

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL JUN 21 1923

20 UNDERTAKER Geo W Little

ADDRESS 2708 EDMONDSON AVE.

mation should be entered, if known, although it may be impossible to obtain it for the back of certificates.
CAUSE OF DEATH in plain terms, so that it may be understood by the public generally.
TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76860

CERTIFICATE OF DEATH.

90 D76860

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1418 Towson St. ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dominic Roach Sr.

(a) RESIDENCE NO. 1418 Towson St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 1 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed or divorced~~ HUSBAND of (or) ~~WIFE of~~ Mary Roach.

6 DATE OF BIRTH (month, day, and year) April 22, 1850.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	1	27.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Puncher
(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Dry Docks.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Edward Roach.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary Ellen ---.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mary Roach. (wife). (Address) 1418 Towson St.

15 Filed JUN 20 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner)

June 18, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. Adco. DATE OF BURIAL June 21 1923

20 UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light St.

CAUSE OF DEATH IS VERY IMPORTANT. See instructions on back of CERTIFICATE

Spec.—1-10-21—M&T—1500 Blks.

D76861 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76861

CERTIFICATE OF DEATH. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1407 W Fayette ST. 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Irene McComas

(a) RESIDENCE NO. 1407 W Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hubert F.

6 DATE OF BIRTH (month, day, and year) Oct 1883

7 AGE Years 39 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Thomas Finnegan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ire.

12 MAIDEN NAME OF MOTHER Emma Devin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hubert F. McComas (Address) 1407 W Fayette

15 Robert P. Harrison; 19 Registrar

Burial Permit Clerk.

JUN 20 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 17 1922 to June 18 1923

that I last saw her alive on June 18 1923

and that death occurred, on the date stated above, at 1-30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No. Microscopic & Chemical

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) 406 5th Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hampden DATE OF BURIAL June 21 1923

20 UNDERTAKER H. Cook ADDRESS 502 E Fayette

mation should be carefully supplied, so that it may be property... CAUSE OF DEATH in plain terms, so that it may be... TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D76862

D76862

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 Compton St. ST., 24 WARD)

2-FULL NAME Frederick Hartmann.

(a) RESIDENCE NO. 1020 Compton ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~or WIFE of~~ Irene Hartmann.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day... hrs. or ....min.
	50	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman, 96
(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore City.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frederick Hartmann.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Fredericka Ricke.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Eva Birrane. (sister).
(Address) 1406 Hanover St.

15 Filed JUN 26 1923 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Unquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto Reinhardt, M. D. (Coroner)

June 18, 1923 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross a a Co. DATE OF BURIAL 6-21 1923

20 UNDERTAKER E & B Stark ADDRESS 112 E Wash 88

CAUSE OF DEATH to be plainly written. See instructions on back of certificate. TION is very important.

D76863

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76863

CERTIFICATE OF DEATH.

199

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St., 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clara Boracki

(Residence in Baltimore: No. 725 S. Broadway St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	White	Single

6-DATE OF BIRTH. Febuary 15, 1902.
(Month) (Day) (Year)

7-AGE. 21 yrs. 4 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Factory Work.
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. George Boracki

11-BIRTHPLACE OF FATHER, (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Anna Kucinski

13-BIRTHPLACE OF MOTHER, (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna Boracki

(Address) 2404 Fleet St.

15-

Filed 192

Robert P. Harrison, Registrar.

JUN 20 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 18/23, 192.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia- abortion

over

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. H. Wallace M. D.
(Coroner.)

6/20/23 192. (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St. Stanislaus Cem. DATE OF BURIAL. June 21. 1923

20-UNDERTAKER. W. J. Sadowski. ADDRESS 905 S. Ann St.

N. B.—Every item of information should be given as required by law. To state CAUSE OF DEATH in plain terms, so that it may be understood by the public, is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76864

CERTIFICATE OF DEATH.

44 D76864

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 So. Milton Ave ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul Kucinski

(a) RESIDENCE NO. 802 S. Milton Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male,	White,	Married,

5a If married, widowed, or divorced (or) WIFE of Frances Kucinska,
HUSBAND of

6 DATE OF BIRTH (month, day, and year) Unknown,

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	58	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer,

(b) General nature of industry, business, or establishment in which employed (or employer) Day,

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland,

PARENTS

10 NAME OF FATHER John Kucinski,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Frances Kucinska, Wife,
(Address) # 802 So. Milton Ave

15 Registrar Robert P. Harrison,

JUN 20 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1923

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1923, to June 19, 1923, that I last saw h alive on June 19, 1923, and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Francis Jansen M. D.

6/19, 1923 (Address) 248 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery, DATE OF BURIAL 6/22/ 1923.

20 UNDERTAKER W. J. Ludowski, ADDRESS 205 S. Ann St

Information should be carefully supplied, so that it may be of value. Use plain terms, so that it may be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

See Letter attached

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76865 Catherine D Daly

CERTIFICATE OF DEATH.

160 D76865

1-PLACE OF DEATH St Vincent's Infant Asy

CITY OF BALTIMORE: (No. 1401 Division ST. 9 WARD)

2-FULL NAME Catherine D Daly (Daly)

(a) RESIDENCE NO. 2309 Greenmount Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 24-1923

7 AGE: Years — Months 4 — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm J. Daly

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Rose Bannon

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Wm J. Daly
(Address) 2309 Greenmount Ave

15 JUN 20 1923 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1923

17 I HEREBY CERTIFY, That I attended deceased from 6/15 , 1923 , to 6/20 , 1923.

that I last saw h[illegible] alive on 6/20 , 1923

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank Goldsborough M. D.

19 (Address) 2735 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet - Frederick Md -

DATE OF BURIAL 6/21/1923

20 UNDERTAKER Wm. Cook - 502 E. North Ave

ADDRESS

mation should be carefully supplied, so that it may be properly c
CAUSE OF DEATH in plain terms, so that it may
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Inability to assimilate food.

HOMEWOOD 2250

CHAS. R. GOLDSBOROUGH, M. D.
2735 N. CHARLES STREET
BALTIMORE

By mistake Mrs Ross Daly's babys na
appears on the death certificate as
Mary Daly - and should have be
Catherine D. Daly -

Chas. R. Goldsborough

June 22 - 1923,

JUN 25 1923

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76866 ✓ D76866

CERTIFICATE OF DEATH.

129 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2029 N. Washington ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Badger Haasen

(a) RESIDENCE NO. 2029 N. Washington St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fredrick F. Haasen

6 DATE OF BIRTH (month, day, and year) July 6. 18x0

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	8x	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Phila. (State or country) Penna.

PARENTS

10 NAME OF FATHER Not known.

11 BIRTHPLACE OF FATHER (city or town) Phila (State or country) Penna.

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) — (State or country)

14 Informant Mrs. Fred. Haasen (Address) 2029 N. Washington St.

15 Filed ..... 19.... Robert P. Harrison, Registrar

JUN 21 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1923

17 I HEREBY CERTIFY, That I attended deceased from May 27 . 1923 . to June 20 . 1923.

that I last saw her alive on June 19 . 1923.

and that death occurred, on the date stated above, at 9.20 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos 23 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine test

(Signed) Jacob Fushin, M. D.

6/20 1923 (Address) 1823 N. Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa - DATE OF BURIAL 6/21/ 1923

20 UNDERTAKER Wm. Cook - ADDRESS 502 E. North ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. And that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D76867

CERTIFICATE OF DEATH.

D76867

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3039 Strickland ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustav Ulrich

(a) RESIDENCE NO. 3039 Strickland ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city ~~or town~~ where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced (or) WIFE of: divorced

6 DATE OF BIRTH (month, day, and year): August 15 1865

7 AGE: Years 57 Months 11 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wood-Work

(b) General nature of industry, business, or establishment in which employed (or employer): Wood Work

(c) Name of employer: Lippman Zenty Baltimore

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER: Henry Ulrich

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Albertina Wissmutzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Matilda Schuchhardt 3039 Strickland St

Filed JUN 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 14 1923

17 I HEREBY CERTIFY, that I attended deceased from Oct. 19 22 to June 19 1923

that I last saw h in live on June 19 1923

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Aortic regurgitation, Chronic Bronchitis Heart Disease, Edema Passive Congestion

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Observation

(Signed) Damian P. Alexander M. D.

19 (Address) 3326 Fridelsheim

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park DATE OF BURIAL: June 22 1923

UNDERTAKER: Jacob Sifer ADDRESS: 1600 N. North Ave

N. B.—WRITE should be carefully supplied. mation should be plain terms, so that it may be p CAUSE OF DEATH in plain terms. See instructions on back of c TION is very important. of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76868

HEALTH DEPARTMENT—CITY OF BALTIMORE D76868

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1632 E. Clement (St.) 24 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes L. Shefke

(a) RESIDENCE NO. 1632 E. Clement ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Alexander Shefke

6 DATE OF BIRTH (month, day, and year): Jan. 8. 1899

7 AGE: Years 24 | Months 5 | Days 11 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Joseph Scroggs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Janney Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Mr. Alex Shefke 1632 E. Clement St.

15 Filed JUN 21 1923, 19..... ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 19th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 21/23. 19..... to June 19/23. 19.....

that I last saw her alive on June 19/23.

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4 mos ..... ds.

CONTRIBUTORY (Secondary) (duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sputum Test

(Signed) Harry B. Hall, M. D.

June 23/23 (Address) 1202 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. Co.

DATE OF BURIAL: June 23 1923

20 UNDERTAKER: Margaret G. Flynn

ADDRESS: 1422 Light St.

N. B.—WRITE plainly and be carefully supplied. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76869

CERTIFICATE OF DEATH.

101-001

D76869

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicolo Mazzarro

(a) RESIDENCE NO. 527 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Salvatoria Mazzarro

6 DATE OF BIRTH (month, day, and year) Dec 24, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Salvator Mazzarro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Salvatori Joseph

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mrs Salvator Mazzarro

(Address) 527 W Lexington St

15 JUN 21 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1923

17 I HEREBY CERTIFY, That I attended deceased from June 4 1923, to June 19 1923

that I last saw him alive on June 19 1923

and that death occurred, on the date stated above, at 2-5 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pleurisy with Effusion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed Luigi L. DiStefano M. D.

June 20, 1923 (Address) 1407 E Exeter St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL 6/22 1923

ADDRESS

20 UNDERTAKER George J. Ruth

135 Harford Av

N. B.—WRITE plainly. Every question should be carefully answered, so that it may be properly classified. Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76870 ✓ 46 D76870

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Dorsey Lane + Monestary ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Jennie S. Abbato

(a) RESIDENCE No. Dorsey Lane Monestary ST., Govans WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles N. Abbato

6 DATE OF BIRTH (month, day, and year) Aug 12-1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles George Rush

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Kunegunda Hahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) Mrs. Abbato Dorsey Lane Monestary Ave

15 Filed JUN 21 1923, 19 ROBERT R. KRANTZ Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1923

17 I HEREBY CERTIFY, That I attended deceased from June, 19 19, to June 19, 19 23,

that I last saw her alive on June 19, 19 23,

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma uteris

Operation 4 yrs ago

General abdominal metastasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Was in this house

Did an operation precede death? No Date of June 1919

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Tomaso J. Mariano M. D.

, 19 (Address) 704 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL 6/22 1923

20 UNDERTAKER George J Ruth

ADDRESS 1735 Harford St

...mation should be carefully supplied, so that it may be properly ...
CAUSE OF DEATH in plain terms, so that it ...
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76871

D76871

CERTIFICATE OF DEATH.

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 Darley Ave ST., 8 WARD)

2-FULL NAME Arthur Leo Powers

(a) RESIDENCE NO. 1617 Darley Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Powers

6 DATE OF BIRTH (month, day, and year) 3/25/1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	45	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Straw hat worker

(b) General nature of industry, business, or establishment in which employed (or employer) Straw hats 8 6

(c) Name of employer Goodmon

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Michael Powers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Nova Scotia

12 MAIDEN NAME OF MOTHER Cathrin Fagen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Agnes Powers (Address) 1617 Darley Ave

15 Filed JUN 21 1923 Registrar

ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1 1923, to June 19 1923, that I last saw him alive on June 18 1923, and that death occurred, on the date stated above, at 9.50 A m.

The CAUSE OF DEATH* was as follows:

Sarcoma Melanotic

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastasis in lungs

1 times (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob Frohm M. D.

6/19 1923 (Address) 1823 N. Wash Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 6/22 1923

20 UNDERTAKER George J Ruth

ADDRESS 1735 Harford Ave

N. B.—Information should be carefully supplied, so that it may be properly entered. CAUSE OF DEATH in plain terms, so that it may be properly entered. CAUSE OF DEATH in plain terms, so that it may be properly entered. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76872

CERTIFICATE OF DEATH.

129 D76872

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 N. Pearl ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Cornish

(a) RESIDENCE NO. 412 Pearl St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1874

7 AGE: Years 49 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer) 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Cornish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Phoebe Foster (Address) 1345 Druid Hill Ave

15 Filed JUN 21 1923 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1923

17 I HEREBY CERTIFY, That I attended deceased from May 31st, 1923, to June 19, 1923, that I last saw him alive on June 19, 1923, 12-30 m. and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White M. D.

, 19 (Address) 1118 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL 6-21-23

UNDERTAKER Paul F. Kenney ADDRESS Druid Hill Ave 1728

N. B.—Information should be carefully [illegible] so that it may be plain terms, so that it may be CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

D76873

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76873

CERTIFICATE OF DEATH.

5 17

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1233 Orleans St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Teich

(Residence in Baltimore: No. 1233 Orleans St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Single

6-DATE OF BIRTH. Jan 2/1862 (Month) (Day) (Year)

7-AGE. 61 yrs. 5 mos. 16 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Broom-vender
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Stephen Teich

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Augusta Kohlerman

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Elizabeth Foster

(Address) 2313 Harford Ave.

15- Filed JUN 21 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 18/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide- cut throat with large knife-

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Jos. H. Blum M. D. (Coroner.)

6/21/23 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. June 22 1923

20-UNDERTAKER. John Zeller ADDRESS 2008 Eastern

N. B.—Every item of information should be given, so that it may be properly recorded. Be sure to state CAUSE OF DEATH in plain terms, so that it may be understood. See instructions on back of certificate. This is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Stroiuk

D76874

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

152 D76874

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 V S Cambridge ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stefan Stroiuk

(a) RESIDENCE. No. 21 V S Cambridge ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 3-1923

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	0	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Andrew Stroiuk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Pauline Patrick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Andrew Stroiuk 21 V S Cambridge St

JUN 21 1923 ROBERT R. KRAMER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 3 . 1923 . to June 19 . 1923 . that I last saw h im alive on June 17 . 1923 . and that death occurred, on the date stated above, at 10.25 p m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) yrs. 5 mos. da.

CONTRIBUTORY (Secondary) Asthma & Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Edward Shrak, M. D.

. 19 (Address) 871 N. Patt. P K. Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	6/21 — 1923
20 UNDERTAKER M F. Sadowski	ADDRESS 905 S Ann

mation should be entered. CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

D76875

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 18 D76875

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE, No. Foot of Kenwood Ave (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen R. Waller

(Residence in Baltimore: No. Sussex Co. Del St.; yrs. mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. Nov 22nd 1905
(Month) (Day) (Year)

7-AGE. 17 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Sailor
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE (State or Country). Del

PARENTS.

10-NAME OF FATHER. Stephen B. Waller

11-BIRTHPLACE OF FATHER (State or Country). Del

12-MAIDEN NAME OF MOTHER. Mary Berridde

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Stepher B. Waller
(Address) Sussex Co. Del

JUN 21 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 20th 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and from Anthony Testimony (Inquest, autopsy or inquiry.) find that said deceased came to ... on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Fenton M. D.
(Coroner)

June 21 1923 (Address) Curtis Bay Md

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Delmar Del. DATE OF BURIAL. 6/21 1923

20-UNDERTAKER. Chas R. Evans Son ADDRESS 118 W. Royal Place

N. B.—Every item of information must be given in plain terms, so that it may be understood. In state CAUSE OF DEATH in plain terms, so that it may be understood. In stating occupation, state what is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

D76876

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D76876

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. 1534 E. Fayette ST., 14 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Ridgley

(a) RESIDENCE NO. 1534 E. Fayette ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) not known

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
39	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Huckster
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS
10 NAME OF FATHER William H Ridgley
11 BIRTHPLACE OF FATHER (city or town) Hanford Co (State or country) Virg
12 MAIDEN NAME OF MOTHER Mary Dennison
13 BIRTHPLACE OF MOTHER (city or town) Perrymans (State or country) Md

14 Informant Annie Johnson
(Address) 522 Thoms st

15 Filed JUN 21 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1923

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1923, to June 15, 1923, that I last saw him alive on June 17, 1923, and that death occurred, on the date stated above, at 11.55 P m.

The CAUSE OF DEATH* was as follows:

Acute Mania

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary) Convulsions Asthenia (duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? no Date of —
Was there an autopsy? no
What test confirmed diagnosis? Repeat Clinical
(Signed) S D Rosdn M. D.
, 19 (Address) 1904 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL June 22 1923

20 UNDERTAKER Chris. W. Johnson ADDRESS 416 N. Caroline St.

mation should be carefully ... so that it may be properly ... CAUSE OF DEATH in plain terms. ... on back of certificates. ... TION is very important. See instructions on ...

Spec.—1-10-21—M&T—1500 Bks. 63

D76876 42 HEALTH DEPARTMENT—CITY OF BALTIMORE 51 D76877

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

2-FULL NAME Ida Sventtal

(a) RESIDENCE NO. 11 S. Eden St ST., WARD City
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. ? mos. ? ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 3, 1913

7 AGE Years 9 Months 8 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Laventhal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bella Spivak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 JUN 21 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1923

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1923. to June 20 1923.
that I last saw her alive on June 20 1923.
and that death occurred, on the date stated above, at 9.25 P. m.

The CAUSE OF DEATH* was as follows:

Chorea with acute rheumatic fever.

(duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Pneumonia (secondary) + acute cardiac dilatation (duration) yrs. mos. 3-4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A.A. Reed, M. D.

. 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehrem Rosedale DATE OF BURIAL June 21 1923

20 UNDERTAKER Jack Leurs ADDRESS 1439 E Balto

Information should be carefully supplied, so that it may be properly classified. Use terms, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

D76878 HEALTH DEPARTMENT—CITY OF BALTIMORE (Frania) D76878

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 909 Trinity ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Frania

(a) RESIDENCE NO. 909 Trinity ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 3 - 1921

7 AGE 1 Years 7 Months 17 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Vincent Frania

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Antonia Mirra

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Nuta Frania 909 Trinity St

15 Filed JUN 21 1923 ROBERT B. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1923, to June 20, 1923, that I last saw him alive on June 19, 1923, and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) measles

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) E. L. Cranford, M. D.

6.20. 1923 (Address) Tow Hills

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 21 1923
20 UNDERTAKER	ADDRESS
George J. Ruth	1738 Hartford Ave.

Information should be carefully supplied, so that it may be permanent. Use ink and write in plain terms, so that it may be properly copied. Do not abbreviate. CAUSE OF DEATH is very important. See instructions on back of certificates.

SAFETY

Cor.—1-12-23—M&T—100 Bks.

D76879

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D76879

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1425 Race St. ST., 23 WARD)

2-FULL NAME Clara E. Luedtke.

(a) RESIDENCE NO. 1425 Race St. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. 5 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) January 7th. 1922.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	5	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Julius Luedtke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Hinkle.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Catherine Luedtke. (mother)
(Address) 1425 Race St.

15 JUN 21 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20th. 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.
unknown.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)
June 21, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL 6/21 1923

20 UNDERTAKER J. Schlosman & Son 1039 Hanover St. ADDRESS

CAUSE OF DEATH in plain terms, ... on back of certificate. TION is very important. See instructions on ...

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76880 HEALTH DEPARTMENT—CITY OF BALTIMORE D76880

CERTIFICATE OF DEATH.

9 | 62

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3306 Harford Rd St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Chas W. & Mildred Burton
Charles Wesley Burton, 3rd

(a) RESIDENCE. NO. 3306 Harford Rd ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Chas W. Burton Jr

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Mildred Meyer

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Chas W. Burton Jr
(Address) 3306 Harford Rd

15 Filed JUN 21 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1923

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1923, to June 21, 1923, that I last saw him alive on June 20, 1923 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wm Pearce M. D.

6-21, 1923 (Address) S E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	June 23 1923
20 UNDERTAKER George Schilling & Sons	ADDRESS 1120 E Monument St

mation should be carefully written in ink, preferably with pen, and may be typewritten. Use only permanent black ink. Do not use copying ink. Do not abbreviate. Use only the accepted medical terms, so that it may be properly classified. Do not report deaths from CAUSE OF DEATH in plain

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Breech Presentation
No injury evident.

Spec.—1-10-21—M&T—1500 Blks.

16471 2 D76881

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D76881

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.

2-FULL NAME George Davis

(a) RESIDENCE NO. 649 Rabaury ST., City WARD)

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Rebecca White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant JOHNS HOPKINS HOSPITAL.

(Address)

15 Filed JUN 21 1923 ROBERT R. KRAUS Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15. 1923. to June 19. 1923. that I last saw him alive on June 19. 1923. and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute miliary Tuberculosis

(duration) Less than 1 mo. - yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) A.A. Wesch, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt auburn DATE OF BURIAL June 24 1923

UNDERTAKER W.B. Gross ADDRESS 1445 McElderry

Information should be carefully supplied, so that it may be properly entered. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATION is very important.

D76882

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76882

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 5420 Wimer St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James T. Berry Jr. (If not over 1 year, St., yrs. mos. ds.)

(Residence in Baltimore: No. 5420 Wimer (Washington Hgts

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH June 22 1866
(Month) (Day) (Year)

7-AGE. 56 yrs. 11 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Marine Indust Mgr
(b) General nature of industry, business, or establishment in which employed (or employer): Balto News

9-BIRTHPLACE, (State or Country). Newport Ky.

PARENTS.

10-NAME OF FATHER. James T Berry

11-BIRTHPLACE OF FATHER, (State or Country). Ky.

12-MAIDEN NAME OF MOTHER. Emma

13-BIRTHPLACE OF MOTHER, (State or Country). Ky.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. Pierce Berry.

(Address) 5420 Wimer st.

15-

Filed JUN 21 1923 192.... ROBERT R. KRAUSE Registrar. Burial Permit Clerk.

N. B.—Every item of information should be given in plain terms, so that it may be possible to state CAUSE OF DEATH in plain terms, so that it may be possible to index of certificate. See instructions on back of certificate. is very important.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 22 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) were find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Arteriosclerosis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(Duration) ....yrs. ....mos. ....ds.

(Signed) John J. Morrissey (Coroner.)

June 23 1923 (Address) 3-32 Roland

*State the Disease causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?....

Former or usual residence....

19-PLACE OF BURIAL OR REMOVAL. Newport Ky. DATE OF BURIAL. 6/21 192..

UNDERTAKER. W J Jahnes & Sons ADDRESS Penna Ave North Ave

Spec.—1-10-21—M&T—1500 Blks.

16460 D76883

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

155 D76883

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (NO.

2-FULL NAME Bessie Caplan

(a) RESIDENCE NO. 263 N. Exeter St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of =

6 DATE OF BIRTH (month, day, and year): August 20, 1918.

7 AGE: Years 3 4 Months 10 Days 1

If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Samuel Caplan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia.

12 MAIDEN NAME OF MOTHER: Ida Cinkinki.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia.

14 Informant: JOHNS HOPKINS HOSPITAL. (Address)

15 JUN 21 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 21 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1923, to June 21, 1923.

that I last saw her alive on June 21, 1923, and that death occurred, on the date stated above, at 4:25 A.m.

The CAUSE OF DEATH* was as follows:

Staphylococcus Septicemia

Origin ?

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Osteomyelitis, pericarditis, pneumonia (duration) yrs. mos. 2-4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A.A. Weech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Cemetery

DATE OF BURIAL 6/21 1923

20 UNDERTAKER: Mat Lawson

ADDRESS 1127 E Baltimore

N. B. Information should be carefully supplied, so that it may be properly entered in the Book of certificates. CAUSE OF DEATH in plain terms, so that it may be properly entered in the Book of certificates. See instructions on back of CERTIFICATE is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76884

CERTIFICATE OF DEATH.

129 D76884

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 10 WARD)

2-FULL NAME Henry F. Evans.

(a) RESIDENCE NO. ~~1232 Greenmount Ave~~ 902 Hartdale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Louisa Evans.

6 DATE OF BIRTH (month, day, and year) Dec 31. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Cooper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm A J. Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherine Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mr. Edmund Evans

(Address) Hendrickville Md

15 Filed JUN 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1923. to June 19, 1923. that I last saw him alive on June 19, 1923. and that death occurred, on the date stated above, at 8 15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff. following Bronchs. Pneumonia. 7 da.

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Chr. Nephritis - (duration) 10 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? S. S. S.

(Signed) Thos R. Geraghty M. D.

June 19 1923 (Address) 2036 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	June 22 1923

20 UNDERTAKER E W Conklin ADDRESS 914 E. Eager

N. B. Information should be carefully supplied, so that it may be properly entered on the certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76885

CERTIFICATE OF DEATH.

129 D76885

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2623 Barclay ST. 17 WARD)

2-FULL NAME Frank G. Simmons

(a) RESIDENCE NO. 2623 Barclay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 5 mos. 15 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of HUSBAND of Sarah M. Simmons

6 DATE OF BIRTH (month, day, and year) Jan. 5. 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 813

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Richard Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country) London - England.

12 MAIDEN NAME OF MOTHER Catherine Kane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Sarah M. Simmons

(Address) 2623 Barclay St.

15 Filed JUN 21 1923 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1920, to June 20 1923, that I last saw him alive on June 19 1923, and that death occurred, on the date stated above, at 1.40 a. m.

The CAUSE OF DEATH* was as follows:

Chron Interstitial Nephritis

(duration) 3 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 3d ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H C Haer, M. D.

June 20 1923 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL June 22 1923

20 UNDERTAKER Jno. & Jno. W. Deufel & Son — ADDRESS 801 N. Fayette

N. B.—Answers should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76886 HEALTH DEPARTMENT—CITY OF BALTIMORE 161-00 D76886

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1436 Ausquith ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Conaway

(a) RESIDENCE NO. 1436 Ausquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F COLOR OR RACE W 5 Single, Married, ~~Widowed~~, or Divorced, ~~(write the word)~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21 1923

7 AGE Years — Months — Days — If LESS than 1 day, hrs. or 3 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) ~~000~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Clarence P Conaway

11 BIRTHPLACE OF FATHER (city or town) Wilmington (State or country) Del

12 MAIDEN NAME OF MOTHER Bessie W. Conway

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Clarence P Conaway (Address) 1436 Ausquith

15 Filed JUN 21 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1923

17 I HEREBY CERTIFY, That I attended deceased from June 21 1923 to June 21 1923.

that I last saw h[illegible] alive on June 21 1923.

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Premature birth (5 months)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Morley Stoag M. D.

19 (Address) 729 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bonnie Brae Cemetery DATE OF BURIAL 6/21 1923

UNDERTAKER James Cignarelli 1000 S Paca St. ADDRESS

N. B. Information should be carefully supplied, so that it may be properly transcribed. CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76887

CERTIFICATE OF DEATH.

161 D76887

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1833 Stoddard ST., 13 WARD)

2-FULL NAME Baby Maddox

(a) RESIDENCE NO. 1833 Stoddard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17-23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Asbury Maddox

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Edith Taylor

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Edith Maddox
(Address) 1833 Stoddard

15 Filed JUN 21 1923, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-17 1923

17 I HEREBY CERTIFY, That I attended deceased from
, 19 , to , 19 ,
that I last saw h alive on , 19
and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Premature delivery

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. McRae M. D.

(Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS JUN 20 1923

N. B.—WRITE plainly and be carefully supplied. Every item should be carefully supplied, so that it may be properly classified. Information should be in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76888 161-80 D76888

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1833 Stoddard ST., 13 WARD)

2-FULL NAME Baby Maddox

(a) RESIDENCE NO. 1833 Stoddard ST., 14 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-17-23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Asbury Maddox

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va

12 MAIDEN NAME OF MOTHER Edith Taylor

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Va

14 Informant Edith Maddox
(Address) 1833 Stoddard

15 Filed JUN 21 1923 Burial Permit Issued Registrar Robert P. Harrison

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-17 19

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h alive on ....., 19....., and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Premature Delivery

.....(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....
.....(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. McRae, M. D.

6/20 1923 (Address) 1126 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS JUN 20 1923

N. B.—WRITE plainly. All information should be carefully supplied. Particularly should CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76889 45 D76889

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home & Inf. 19 WARD)

CITY OF BALTIMORE: (NO. 126 N. Broadway ST.,

2-FULL NAME Mrs. Henry Lucas

(a) RESIDENCE NO. 10 S. Belnord Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed,~~ or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M. Lucas

6 DATE OF BIRTH (month, day, and year) April 17 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	2	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Butcher
(b) General nature of industry, business, or establishment in which employed (or employer) 0/5
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS
10 NAME OF FATHER Bernard Lucas
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy
12 MAIDEN NAME OF MOTHER Antonia B. Voss
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Annie M. Lucas
(Address) 10 S. Belnord Ave

15 Robert P. Harrison, Registrar
N 21 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1923

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1923, to June 20, 1923, that I last saw h.. alive on June 20, 1923 and that death occurred, on the date stated above, at 4 16 A. m.

The CAUSE OF DEATH* was as follows:
Carcinoma Sigmoid
General Peritonitis following operation (duration) ..... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Carcinoma Sigmoid (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? Yes Date of June 13 1923
Was there an autopsy? No
What test confirmed diagnosis? Operation & Clinical
(Signed) Richard G. Cobbett, M. D.
(Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Trinity Cem. Boucle	June 23 1923
20 UNDERTAKER	ADDRESS
Jos Loerdens, Son	217 S. Broadway

B.—WRITE should be carefully supplied, so that it may be properly classified. Information should be given in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D76890

D76890

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH: CITY OF BALTIMORE: (No.) General German Aged Home (WARD) 20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margarette E Volbracht

(a) RESIDENCE. NO. N. E Cor Baltimore Payson ST.

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 27. 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Samuel Arndt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Helene Kuchmeer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Record of German Aged Home

(Address) Balto & Payson St

Filed JUN 21 1923 Robert P. Harrison, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1922, to June 20th 1923,

that I last saw her alive on June 18th 1923,

and that death occurred, on the date stated above, at 12.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Houff M. D

6/21 1923 (Address) 1843 W Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: June 22 1923

20 UNDERTAKER Joseph B. Cook — ADDRESS 1013 N Balto St

mation should be entered in plain terms, so that it may be properly
CAUSE OF DEATH in plain terms.
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Blks.

D76891 HEALTH DEPARTMENT—CITY OF BALTIMORE

129 D76891

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alex Mitchell

(a) Residence No. 2303 Oak St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1870

7-AGE. 52 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). North Carolina

PARENTS.

10-NAME OF FATHER, Wm. Mitchell

11-BIRTHPLACE OF FATHER (city or town) (State or Country). N. Carolina

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). N. Carolina

11- (Informant) Municipal Hospital Records

(Address)

15- Filed JUN 21 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

should be carefully read, so that it may be properly classified. in plain terms, so that it may be properly classified. instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 19, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 7 19 23 to June 19 19 23

that I last saw h. im alive on June 19 19 23

and that death occurred, on the date stated above, at 2:15 P. M.

The CAUSE OF DEATH* was as follows:

Pyonephrosis, nephritis, arm
Mediastinal abscess
adhesive pericarditis + fibrous + fibrinous pleurisy (Duration) P yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) N. Goldwater, M. D.

6-20-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL, 6-22-1923

20-UNDERTAKER, Dan'l Conkin — ADDRESS 916 Park Ave

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum*, etc. *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Chronic Nephritis

Spec. 7-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76892

D76892

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (NO. ... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Frank Henry.

(a) RESIDENCE NO. 301 N. Fremont Ave ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Blk.

5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown.

6 DATE OF BIRTH (month, day, and year): 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labourer.

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland.

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do.

12 MAIDEN NAME OF MOTHER: Do.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant: Wm. Henry

(Address): 301 N. Fremont Ave

15 Filed ... 19 ... Registrar

Burial Permit Clerk.

JUN 21 1923

B.—WRITE PLAINLY. Items must be carefully supplied. Abbreviations may be properly used. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-19-1923

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1923, to June 19, 1923, (that I last saw him alive on June 19, 1923 and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Hypertension & Myocardial Insufficiency (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of ...

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) H. C. Goldsmith M. D.

, 19 (Address) Bay View Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loud Eaton

DATE OF BURIAL: 6-22-1923

20 UNDERTAKER: Loud Eaton

ADDRESS 916 Pa ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76893

CERTIFICATE OF DEATH.

3 1 ✓ D76893

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 816 N. 36th. St. ST., 13 WARD)

2-FULL NAME James B. Edrington

(a) RESIDENCE NO. 816 N. 36th. St. ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 11 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Geraldine E. Edrington

6 DATE OF BIRTH (month, day, and year): July 4-1886

7 AGE — Years: 36 — Months: 11 — Days: 16 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): 109

(c) Name of employer: J. P. Pfeiffer & Son

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: John B. Edrington

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mollie Booker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Maryland

14 Informant (Address): Mrs. Geraldine E. Edrington 816 N. 36th. St.

15 [illegible] 19 .19 Robert P. Harrison, Registrar

Burial Permit Clerk.

N 21 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to June 20, 1923.

that I last saw him alive on June 20, 1923.,

and that death occurred, on the date stated above, at 7 45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of —

Was there an autopsy? —no—

What test confirmed diagnosis? Yes

(Signed) [illegible] M. D.

, 19 (Address) 810 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: June 22 1923

UNDERTAKER: Horace M. Burgee — ADDRESS: 3621 Falls Rd.

mation should be carefully supplied, so that it may be p
CAUSE OF DEATH in plain terms, so that it may be p
TION is very important See instructions on back of c

Spec.—1-10-21—M&T—1500 Bks.

D76894

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76894

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3803 Harrison Ave St. 15 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Henry Horn

(a) RESIDENCE No. 3803 Harrison Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosina Horn

6 DATE OF BIRTH (month, day, and year) June 27, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	53	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jess. Horn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Grace Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs. Rosina Horn

(Address) 3803 Harrison Ave

15 Filed JUN 21 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1923

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1923, to June 18, 1923.

that I last saw him alive on June 18, 1923,

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia & Myocarditis

(duration) yrs. mos 24 ds.

CONTRIBUTORY (Secondary) Diabetes (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? No Date of June 15 23

Was there an autopsy? No

What test confirmed diagnosis? Examination & Chemical

(Signed) J Purvis, M. D.

, 19 (Address) Glyndon Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem DATE OF BURIAL June 22, 23

20 UNDERTAKER Wm J Tickner & Sons ADDRESS Woodlawn

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76895 D76895

CERTIFICATE OF DEATH.

129

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2310 Avalon Ave ST., 13 WARD)

2-FULL NAME Casper Bishop Sloan

(a) RESIDENCE NO. 2310 Avalon Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Matilda C. Sloan

6 DATE OF BIRTH (month, day, and year): Sept. 14 1839

7 AGE — Years: 85 — Months: 9 — Days: 24 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): for
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Vt.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Vt.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Vt.

14 Informant (Address): Mr. Henry D. Fronsuth 2310 Avalon Ave.

15 JUN 21 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 8 1921 to June 20 1923, that I last saw h.. alive on June 20 1923, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:
Cronic Staphylococcus
and Endocarditis
Staphylococcus (duration) 3 yrs. mos ds.
CONTRIBUTORY (Secondary) Endocarditis
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?.....
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) A. D. Blumgart M. D.
, 19 (Address) 710 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: June 22 23

20 UNDERTAKER: Wm. Pickner Sons

ADDRESS: Forest Pl

Information should be carefully supplied so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

D76896 HEALTH DEPARTMENT—CITY OF BALTIMORE D76896

CERTIFICATE OF DEATH.

188-203 Mt. Auburn

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Homewood Hospital 16th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lillian C. Foster

(Residence in Baltimore; No. 2901 Nicholas St. Or 1824 Bolton St. aus. 12 St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, Oct. (Month) 12 (Day) 1877 (Year)

7-AGE, 46 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country) Canada

PARENTS.

10-NAME OF FATHER, Wm. Cobpi

11-BIRTHPLACE OF FATHER, (State or Country) England

12-MAIDEN NAME OF MOTHER, Caroline Thomas

13-BIRTHPLACE OF MOTHER, (State or Country) England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. P. B. Foster

(Address) 2901 Nicholas

15-

Filed June 21 1923 Robert F. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 20 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry.) find that said deceased came to ... death on the day stated above.

THE CAUSE OF DEATH was as follows:

Fractured base of skull (Accidental)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Ambrose Russell M. D. (Coroner)

June 21 1923 (Address) 1632 Bolton

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Wood Lawn DATE OF BURIAL. June 22 1923

20-UNDERTAKER. Wm Cook ADDRESS 502 Nadar

N. B.—Every item of information must be given in plain terms, so that it may be understood. Do not state CAUSE OF DEATH in plain terms, so that it may be understood. Do not state CAUSE OF DEATH in plain terms, so that it may be understood. Do not state CAUSE OF DEATH

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76897

CERTIFICATE OF DEATH.

+90 ✓ D76897

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Minnie Gatewood

(Residence in Baltimore: No. Linwood, West Va - St.; yrs., 11 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, not Known (Month) (Day), 1886 (Year)

7-AGE, 37 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), West Virginia

PARENTS.

10-NAME OF FATHER, not known

11-BIRTHPLACE OF FATHER (State or Country), not known

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph H Akers

(Address) Johns Hopkins Hosp

15- JUN 22 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit issued.

N. B. CAUSE OF DEATH in plain terms, so that it may be properly classified. All items important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 20 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 17 1922, to June 20 1923, that I saw her alive on June 20 1923, and that death occurred, on the date stated above, at 6 45 Pm.

The CAUSE OF DEATH* was as follows:-

Myocardial degeneration

with Mitral Stenosis

(Duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(Duration) yrs. 10 mos. ds.

(Signed) Joseph H Akers M. D.

June 20, 1923 (Address) Johns Hopkins Hosp

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 6 yrs. 11 mos. 4 ds. In the State yrs. 11 mos. 4 ds.

Where was disease contracted, if not at place of death? West Virginia

Former or usual residence Linwood, West Virginia

19-PLACE OF BURIAL OR REMOVAL, Elkins W Va

DATE OF BURIAL, June 27 1923

20-UNDERTAKER Joseph Akers

ADDRESS 721 Bway

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76898

CERTIFICATE OF DEATH.

D76898

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2412 W. Lombard St. ST., 20 WARD)

2-FULL NAME Isabelle Heilman

(a) RESIDENCE No. 2412 W. Lombard St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 21, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Rudolph C. Heilman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Nettie B. Hoover

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Rudolph C. Heilman

(Address) 2412 W. Lombard St.

15 JUN 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21st 19 23

17

I HEREBY CERTIFY, That I attended deceased from June 19, 1923, to June 21, 1923, that I last saw h[illegible] alive on June 21, 1923, and that death occurred, on the date stated above, at 3-45 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Measles

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Robt J. Murray M.D. M. D.

(Address) 510 N. Fremont St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL June 22nd 1923

20 UNDERTAKER Joseph B. Cook

ADDRESS 503 W. Balto St.

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76899

CERTIFICATE OF DEATH.

21 D76899

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital, St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margie Taylor

(a) Residence No. 1626 Madison Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1902

7-AGE. 21 yrs. mos. ds. | If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Virginia

PARENTS

10-NAME OF FATHER, James Hall

11-BIRTHPLACE OF FATHER (city or town) (State or Country), ?

12-MAIDEN NAME OF MOTHER, Miranda Hall

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), England

11- (Informant) Municipal Hospital Records
(Address)

15-
Filed JUN 22 1923 Robert R. KRAUTER, Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 21, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 11 1923 to June 21 1923 that I last saw her alive on June 20 1923 and that death occurred, on the date stated above, at 3:00 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) N. Goldsmith Attending M. D.

6-21-23 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Makemie Park Va. Sanford Va. VIA P.R.R. DATE OF BURIAL. June 22 1923

20-UNDERTAKER. John F. Denny ADDRESS 715 Light St

Should be filled in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76900

CERTIFICATE OF DEATH.

65-00 D76900

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 531 N.Kenwood Ave. ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M.E.Wehrhahn

(a) RESIDENCE NO. 531 N.Kenwood Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frank H.Wehrhahn

6 DATE OF BIRTH (month, day, and year) May 19 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work 537

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John H.Valentine

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna J.Myers

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Frank H.Wehrhahn
(Address) 531 N.Kenwood Ave.

15 JUN 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1923

17 I HEREBY CERTIFY, That I attended deceased from June 11th, 1923, to June 20, 1923

that I last saw h. alive on June 20, 1923

and that death occurred, on the date stated above, at 10.45 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis (Syphilis)

Lues

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscop. Chem. C

(Signed) Wegenstorfer, M. D.

, 19 (Address) 4082 5th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL June 25 1923

20 UNDERTAKER John H. Denny — ADDRESS 715 Light St

Information should be careful, complete, so that it may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

D76901 HEALTH DEPARTMENT—CITY OF BALTIMORE D76901

CERTIFICATE OF DEATH.

118-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Hosp. 2724 N. Charles ST., V WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Hattie A. Eyler

(a) RESIDENCE NO. 212 Warren Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Daniel B. Eyler

6 DATE OF BIRTH (month, day, and year) Feb 12, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	63	4	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 037
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thos. E. Salter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Harriett C. Yearley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Daniel B. Eyler
(Address) 212 Warren Ave

15 Filed JUN 22 1923, 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr. 23, 1923, to June 21, 1923, that I last saw h[e] alive on June 21, 1923, and that death occurred, on the date stated above, at 10.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease.
(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) Inguinal Hernia
(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of May 9, 1923.

Was there an autopsy? No.

What test confirmed diagnosis? .....

(Signed) Vernon H. Condon, M. D.

, 19 (Address) 750 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	June 25 1923
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76902

D76902

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3301 Gwynn Oak Avenue St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Lamuel Thomas

(a) Residence No. 3301 Gwynn Oak Avenue St., 28 Ward. Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 6 mos. 3 ds. How long in U. S., if of foreign birth? 57 yrs. 6 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Hunt Thomas

6-DATE OF BIRTH (month, day and year) Dec-19-1865

7-AGE. 57 yrs. 6 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Painting 050

(b) General nature of industry, business, or establishment in which employed (or employer). Contractor

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Maryland

PARENTS

10-NAME OF FATHER. James Thomas

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore Maryland

12-MAIDEN NAME OF MOTHER. Delia F. Mentzel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Maryland

11- (Informant). Mrs. E. Vernon Murphy (Sister)
(Address) 3301 Gwynn Oak Avenue

15-
Filed JUN 22 1923 192.... Registrar. ROBERT B. KRAUTHOFF
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 21-1923

17- I HEREBY CERTIFY, That I attended deceased from Jany. 1921 to June 21, 1923.

that I last saw h. alive on June 20 1923.

and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

diabetis mel. and
chronic nephritis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No signs and symptoms.

What test confirmed diagnosis? chem. & microsc. exam.

(Signed) T. S. Stemmler M. D.

June 21, 1923 (Address) 2226 Madison ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Green Mount Cemetery — DATE OF BURIAL. June-23-23

20-UNDERTAKER. ROBERT F. KRAUTHOFF & MOWEN COMPANY — ADDRESS 109 W. NORTH AVE.

Should be filled in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D76903

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76903

CERTIFICATE OF DEATH.

15 58-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3023 Clifton Avenue ..... St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mallory Whiting Webster

(a) Residence No. 3023 Clifton Avenue ..... St., 15 Ward. Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 30 yrs. 10 mos. 28 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July-23-1892

7-AGE. 30 yrs. 10 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

(c) Name of employer ..... None

9-BIRTHPLACE (city or town) Sparrows Point
(State or Country) Maryland

PARENTS.

10-NAME OF FATHER, Frederick L Webster

11-BIRTHPLACE OF FATHER (city or town) Cuba
(State or Country) New York

12-MAIDEN NAME OF MOTHER, Mary Whiting

13-BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or Country) Maryland

11- (Informant) Frederick L Webster (father)

(Address) 3023 Clifton Avenue

15-

Filed ..... 192 ..... Registrar.

JUN 22 1923 ROBERT R. KRAUTER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June-20-1923.

17- I HEREBY CERTIFY, That I attended deceased from April ..... 1922, to 6/20 ..... 1923.

that I last saw h.. alive on 6/20 1923

and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Pernicious anaemia

2
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY —
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? Laboratory

What test confirmed diagnosis? Pathological

(Signed) ..... M. D

6/21, 1923 (Address) 10[illegible] Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Green Mount Cemetery

DATE OF BURIAL. June-22-23

20-UNDERTAKER. STEWART & [illegible]

ADDRESS [illegible] AVE.

Should be filled out so that it may be properly classified in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76904 HEALTH DEPARTMENT—CITY OF BALTIMORE D76904

D76904 CERTIFICATE OF DEATH. Registered No. 129

1-PLACE OF DEATH
City of BALTIMORE: (No. 142 Wilson St., 14 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Clara Eliza Rush
(a) Residence No. 142 Wilson St., 14 Ward. Resident
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 71 yrs. 5 mos. 2 ds. How long in U. S., if of foreign birth? 71 yrs. 5 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female
4-COLOR OR RACE: White
5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6-DATE OF BIRTH (month, day and year): Jany 18 1852

7-AGE. 71 yrs. 5 mos. 2 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none
(c) Name of employer: none

9-BIRTHPLACE (city or town) (State or Country): Baltimore Maryland

PARENTS.
10-NAME OF FATHER: Jacob Rush
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore Maryland
12-MAIDEN NAME OF MOTHER: Eliza Tracey
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore Maryland

11-(Informant): Miss Mary F. Rush
(Address): 142 Wilson St.

13-Filed JUN 22 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 20 1923

17- I HEREBY CERTIFY, That I attended deceased from May 24 1923 to June 20 1923
that I last saw her alive on June 20 1923
and that death occurred, on the date stated above, at 12.45 p m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
(Duration) Several yrs.
CONTRIBUTORY (Secondary) Uremia
(Duration) 3 ds.

18-Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Urinary
(Signed) Edwin K. Ballard M. D
6-20 1923 (Address) 1622 Mt Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery
DATE OF BURIAL. June 23 1923
20-UNDERTAKER: STEWART & MOWEN COMPANY
ADDRESS 100 W. NORTH AVE.
WILLIAM F. WOODER, Supervisor

Should be written in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76905

CERTIFICATE OF DEATH.

185 D76905

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 Radnor Avenue ST.: 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edwin Edgar Montell

(Residence in Baltimore: No. 507 Radnor Avenue St.; 79 yrs., 2 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
Male	White	Single

6-DATE OF BIRTH, March 31 1844, 1
(Month) (Day) (Year)

7-AGE, 79 yrs. 2 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9-BIRTHPLACE, (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, James E. Montell

11-BIRTHPLACE OF FATHER (State or Country), Nassau Bahama Island

12-MAIDEN NAME OF MOTHER Mary Coward

13-BIRTHPLACE OF MOTHER (State or Country), Not Known Eastern Shore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. E. Montell (Wife)

(Address) 507 Radnor Avenue

15-

Filed....., 191..... Registrar

JUN 22 1923 Judd Perrill Clerk

N. B.—Every item must be filled in plain terms, so that it may be properly understood. CAUSE OF DEATH important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 20, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 7 1923, to June 20 1923, that I saw him alive on June 20 1923, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows: (over)
Senile Pneumonia of Left Side
Complicated with Fracture of
Neck of Femur of Left Side
(Duration) yrs. mos. 13 ds.
CONTRIBUTORY (Secondary) Valvular Heart disease
(Duration) yrs. mos. ds.

(Signed) E. E. Duncan M. D.
June 20, 1923 (Address) 5106 York Road.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Green Mount Cemetery — DATE OF BURIAL, June 22, 23

20-UNDERTAKER STEWART & MOWER COMPANY (WILLIAM F. WOOD, Successor) — ADDRESS 108 W. NORTH AVE.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76906

CERTIFICATE OF DEATH.

3 D76906

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 W. 25th ST., 12 WARD)

2-FULL NAME Maurica Coleman

(a) RESIDENCE NO. 100 W. 25th ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. Maury Coleman

6 DATE OF BIRTH (month, day, and year) October 3, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond
(State or country) Va.

PARENTS

10 NAME OF FATHER Phillip Marks

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New York

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New York

14 Informant W. Maury Coleman
(Address) 100 W. 25th St.

15 Filed JUN 22 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1923, to June 21, 1923, that I last saw her alive on June 21, 1923, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Epilepsy
(duration) yrs. Years ds.
Chronic Nephritis
CONTRIBUTORY (Secondary) Cause
(duration) yrs. 4 mos. 2 days

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ind. Stain Sanalysis

(Signed) L. A. Richardson M. D.

June 22, 1923 (Address) 1121 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL June 22 1923

20 UNDERTAKER Harvey A. Witzke — ADDRESS 1534 W. Lombard St

mation should be carefully supplied, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76907

CERTIFICATE OF DEATH.

129 ✓ D76907

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 E. Fort Ave. ST., 24 WARD)

2-FULL NAME Grace May Kelley

(a) RESIDENCE NO. 512 E. Fort Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 10 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William A. Kelley

6 DATE OF BIRTH (month, day, and year) Aug. 19 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	32	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Franklin S. Thompson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Dora Meseke

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Wm. A. Kelley
(Address) 512 E. Fort Ave.

15 Registered JUN 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1922, to June 20, 1923.

that I last saw h[illegible] alive on June 20, 1923.

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) Sidney A. Street M. D.

6/21, 1923 (Address) 405 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 6/23 1923

20 UNDERTAKER J. H. Mc. Cully

ADDRESS 130 E. Fort

mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D76908

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76908

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dangerfield Lee

(a) Residence No. 720 George St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Black	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): 1850

7-AGE. 72 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: James Lee

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14- (Informant) Municipal Hospital Records

(Address)

15- Filed JUN 22 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

Should be filled in plain terms, so that it may be properly classified. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 18, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 23 19 23 to June 18 19 23

that I last saw him alive on June 18 19 23

and that death occurred, on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Goldsmith M. D.

6-19-23 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury — DATE OF BURIAL: June 22 1923

20-UNDERTAKER: John E. Henderson — ADDRESS 1502 E Monument

Spec.-1-10-21-M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76909

CERTIFICATE OF DEATH.

129 D76909

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 207 S Fulton Ave ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eda E. Paul

(a) RESIDENCE NO. 207 S Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? 69 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Paul

6 DATE OF BIRTH (month, day, and year) Aug 23-1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ....min.
	78.	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Frantz H. Adnet,

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Alberta

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant John Paul 1104 E. Eutaw St

(Address)

JUN 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17. 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1. 1923. to June 17. 1923.

that I last saw her alive on June 17. 1923.

and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(duration) yrs. 6. mos. ds.

CONTRIBUTORY (Secondary) Collapse

(duration) yrs. mos. 1. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) O. Pilson M. D.

, 19 (Address) 336 S. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL June 22nd 23

20 UNDERTAKER Geo L. Schwartzrock ADDRESS 1116 Fulton Ave

mation should be entered, and that it may be properly classified. PLACE OF DEATH, CAUSE OF DEATH in plain terms, so

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76910

CERTIFICATE OF DEATH.

38 D76910

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 E Pratt St., 3 WARD)

2-FULL NAME Bailey Johnson

(a) RESIDENCE No. 1128 E Pratt ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~or Wife of~~ Leona Johnson

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE: Years 26 | Months | Days | If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Ship-Building

(c) Name of employer Curley Rhodes Sons St Clutch

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Henry Williams
(Address) 713 S. Longest

15 JUN 22 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1923

17 I HEREBY CERTIFY, That I attended deceased from June 19 1923 to June 21 1923, that I last saw h in alive on June 20 1923, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of Brain causing Catalepsis Paralysis Tongue & Jaw Left

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Heat Stroke prn

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Richard L Eschenfelder M. D.

19 (Address) 1510 E Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR REMOVAL ~~St. Mary's Cem. Balto~~ Loudon Park Cem. | DATE OF BURIAL June 22 1923

20 UNDERTAKER Lasbury Bros | ADDRESS Miltas Davis 315 N Eden St

mation should be carefully supplied, so that it may be properly classified. Entry CAUSE OF DEATH in plain terms, so that it TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Letofsky

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76911

CERTIFICATE OF DEATH.

74-001 D76911

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2011 Christian St., 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chia Rachel Letofsky

(a) RESIDENCE NO. 2011 Christian St ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., if of foreign birth? 9 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Noah Letofsky

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Vaselkov Kiev-Russia

PARENTS

10 NAME OF FATHER Israel Gabai

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 E Balto St

15 JUN 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-21 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 15 1923, to June 21 1923.

that I last saw her alive on June 21 1923.

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) — yrs. 5 hours. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Nathan B Bodenheimer M. D.

6/21 1923 (Address) 2114 Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Wash Road — DATE OF BURIAL 6/22/1923

20 UNDERTAKER Jack Lewis 1439 — ADDRESS E Balto

mation should be entered, suppress ... that it may be properly classified. Early information should be entered, suppress ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Early information should be entered, suppress ... TION is very important. See instructions on back of certificates.

KODAK S.S.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76912

CERTIFICATE OF DEATH.

111-001 D76912

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1508 N. Strieker ST., 15 WARD)

2-FULL NAME John Frank Carroll

(a) RESIDENCE NO. 1508 N. Strieker ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Hannie Carroll

6 DATE OF BIRTH (month, day, and year) July 4 1883.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
39		11	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer) Grocery Store
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Hannie Carroll,
(Address) 1508 N. Strieker St

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar.
JUN 22 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10th 1923. to June 19th 1923.
that I last saw h alive on June 18 1923
and that death occurred, on the date stated above, at 4A. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcers. over
Cardiac End of Stomach
(duration) yrs. 2 mos ds.

CONTRIBUTORY, Hematemesis + Asthenia
(Secondary) (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of

Was there an autopsy? no Physical Examination

What test confirmed diagnosis?

(Signed) Harry L. Brown M. D.

6/20. 1923 (Address) 50 Freedman ex

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL OR CREMATION Loudon Park DATE OF BURIAL 6/23/23

20 UNDERTAKER Samuel Hendry ADDRESS 1115 W Balto

Information should be carefully supplied. ACCURATE statement of facts is required. Each item should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76913

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76913

CERTIFICATE OF DEATH.

139

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 946 Pennsylvania ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida L. Allen

(a) RESIDENCE. NO. 744 Penna ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Aug 15 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Manchester Va.

PARENTS

10 NAME OF FATHER Alexander Briggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Manchester Va

12 MAIDEN NAME OF MOTHER Mary Hopkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Manchester Va

14 Informant (Address) Same 946 Pennsylvania Ave

15 JUN 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH June 19

16 DATE OF DEATH (month, day, and year) June 19 1923

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1923, to Jun 19, 1923, that I last saw h[illegible] alive on Jun 19, 1923, and that death occurred, on the date stated above, at 8.50 A. m.

The CAUSE OF DEATH* was as follows: Febrile d Lumo

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Co olerum d

(duration) yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death? Febrile d Lumo

Did an operation precede death? no Date of June 18/23

Was there an autopsy? No

What test confirmed diagnosis? Febrile d Lumo

(Signed) C. R. Finlay, M. D.

, 19 (Address) 728 Marshall Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 6/25 19

20 UNDERTAKER Sam'l Handley

ADDRESS [illegible]

mation should be carefully supplied. As it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

J. Ulmer

Spec.—1-10-21—M&T—1500 Bks.

Linquer

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76914

D76914

CERTIFICATE OF DEATH.

162

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Linquer

(a) RESIDENCE NO. 211 Collington Ave SE., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 18-23.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Conrad Linquer

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Ruth Long

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant W. W. Gray (Address) Johns Hopkins Hosp.

15 JUN 22 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1923

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1923, to June 20 1923, that I last saw him alive on June 20, 1923, and that death occurred, on the date stated above, at 7.00 P.m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. W. Gray, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL June 23, 1923

20 UNDERTAKER John Zellick ADDRESS 2108 Eutaw

mation should be carefully supplied. Each question must be answered so that it may be properly classified. Exact information is required. Write plainly in ink. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact information is required. Write plainly in ink. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓

D76915 REGISTERED NO.

D76915
1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Bender

(a) RESIDENCE NO. 1431 Gough St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or . min.
	60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 JUN 22 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1923

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1923, to June 18, 1923, that I last saw her alive on June 18, 1923, and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:
Cardiac Decompensation

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism (duration) yrs. mos. 1/2 hr.

18 Where was disease contracted if not at place of death? Hospital

Did an operation precede death? No Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) C. M. Shipley, M. D.

6-18-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemeteries — DATE OF BURIAL June 22 1923

20 UNDERTAKER Mr-Mrs Fink — ADDRESS 1737 Pault st

Information should be carefully supplied. Exact statement of facts may be properly classified. Any person who shall wilfully make a false statement of any of the facts required to be stated in this certificate, so that it

D76916

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76916

CERTIFICATE OF DEATH.

1923 6

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephan Brown

(Residence in Baltimore: No. 1616 Mullikin St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: col

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Nov 20 1892 (Month) (Day) (Year)

7-AGE: 31 yrs. 7 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Boot-black
(b) General nature of industry, business, or establishment in which employed (or employer): 086

9-BIRTHPLACE (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Stephen Brown

11-BIRTHPLACE OF FATHER, (State or Country): St. Marys Co. Md.

12-MAIDEN NAME OF MOTHER: Arey Williams

13-BIRTHPLACE OF MOTHER, (State or Country): St. Marys Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hattie Gleaves

(Address) 824 Mc Donough St.

15- Filed JUN 22 1923 192 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

N. B.—Every item of information should be properly entered, so that it may be plainly and correctly understood. Use plain terms, so that it may be properly classified. State CAUSE OF DEATH in plain terms, so that it may be properly classified. Leave no blanks. Write plainly in ink. Every certificate is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 19/23 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide- stab through heart

autopsy by Dr. Maldeis-

Inquest to be held June23/23

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. J. Waesche M. D. (Coroner.)

6/22/23 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). In the place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Ashbury Cemetery DATE OF BURIAL. 6/24/23 19...

20-UNDERTAKER. ADDRESS Peter F. Williams-1615 Mc Elderry st

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

60-001 ✓ D76917

D76917 REGISTERED NO.

1-PLACE OF DEATH 1733 N. Bradford St. 8 WARD)

CITY OF BALTIMORE: (No. 1733 N. Bradford ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary B. Gross

(a) RESIDENCE NO. 1733 N. Bradford ST., 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 10 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Nicholas M Gross

6 DATE OF BIRTH (month, day, and year): Aug 12 1857

7 AGE: Years 65 Months 10 Days 8 If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Henry Herfel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Regina Reutelgone

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Nicholas M Gross husband (Address) 1733 N. Bradford St

15 FILED JUN 22 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 20 1923

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1923, to June 20, 1923, that I last saw her alive on June 20, 1923, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) 2 yrs. mos. 0 ds.

CONTRIBUTORY (Secondary) Exophthalmic goitre

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual test

(Signed) Edward Macdonald, M. D.

(Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery DATE OF BURIAL: June 23 23

20 UNDERTAKER: Fred'k Loeffler Sons ADDRESS: Fallston

mation should be carefully supplied, so that it may be properly classified. Exact information CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76918 — CERTIFICATE OF DEATH. — 90 ✓ — D76918

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 431 Dchester ave ST.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Harris

(Residence in Baltimore: No. 431 Dchester ave St.; 6 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, June (Month) 17 (Day), 1847 (Year)

7-AGE, 76 yrs. mos. ds.

If LESS than 1 day. hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Garage
(b) General nature of industry, business, or establishment in which employed (or employer) Retired

9-BIRTHPLACE, (State or Country), Penn.

PARENTS.

10-NAME OF FATHER, John Harris

11-BIRTHPLACE OF FATHER (State or Country), Penn

12-MAIDEN NAME OF MOTHER Rebecca Lloyd

13-BIRTHPLACE OF MOTHER (State or Country), Penn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Harris

(Address) 2828 Linkwood Ave

15- Filed JUN 22 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 20th (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 13th 1923 to June 20th 1923, that I saw h[im] alive on June 18 1923, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, and
general weakness

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Heat Prostration

(Duration) yrs. mos. ds.

(Signed) H. Stanley Gosnell M.D.

6/21, 1923 (Address) 2900 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet — DATE OF BURIAL, June 23 1923

20-UNDERTAKER E. A. Friedfeld — ADDRESS 501 E 25th St

Spec—12-20-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76918 CERTIFICATE OF DEATH. D76919

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 26 Ward) Registered No. 100-00

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Watts

(a) Residence No. R.V.A. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (Write the word.)
Female	Black	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1840

7-AGE. 83 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Calvert Co., Md.

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country),

14- (Informant) Municipal Hospital Records

(Address) UNIVERSITY OF MARYLAND

15- Filed JUN 22 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

0495

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 20, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 11 1923 to June 20 1923 that I last saw h... alive on June 20 1923 and that death occurred, on the date stated above, at 11:40 A.M.

The CAUSE OF DEATH* was as follows:

Senility

Exhaustion

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (Terminal) (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Fedrwith M. D.

6-21 1923 (Address) Municipal Hospital,

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, ... 19....

20-UNDERTAKER. ADDRESS JUN 22 1923

Should be written in plain terms, so that it may be properly classified. See instructions on back of certificates.

196

Spec.-1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

23 D76920

REGISTERED NO. D76920

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Allen

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed JUN 22 1923 JUN 24 Permit Clerk. ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20, 1923

17 I HEREBY CERTIFY, That I attended deceased from October 25 1923 to June 20 1923.

that I last saw him alive on June 20 1923.

and that death occurred, on the date stated above, at 2:20 P.M.

The CAUSE OF DEATH* was as follows:

Lethargic Encephalitis

(Epidemic Encephalitis)

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (Terminal) (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) N. Gedamith M. D.

6-21-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

ADDRESS

20 UNDERTAKER

UNIVERSITY OF MARYLAND JUN 27 19

mation should be carefully answered in full. Every question must be answered, or the certificate may be improperly classified. Use only CAUSE OF DEATH in plain terms, so that it may be properly classified. Every question must be answered, or the certificate may be improperly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 D76921

D76921

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 607 S Rose ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Valentine Schonhoff

(a) RESIDENCE NO. 607 S Rose ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Joan Schonhoff.

6 DATE OF BIRTH (month, day, and year) Dec 22nd

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	6.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman of Street

(b) General nature of industry, business, or establishment in which employed (or employer) cleaners. 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Barbara Fry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Joan Schonhoff. 607 S Rose St

15 JUN 22 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1923

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1923, to June 21, 1923, that I last saw him alive on June 21, 1923, and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. Months.

CONTRIBUTORY (Secondary) Dunstroke

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard Jamgochian M.D.

6/22, 1923 (Address) 243 Falt Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	June 25 1923
20 UNDERTAKER Robt J Turner Inc	ADDRESS 1446 N Broadway

mation should be carefully supplied. Each statement may be properly classified. Examine CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

401 E 25th St.

D76922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76922

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 924 Homestead ST., WARD 9

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Thomas Rice

(a) RESIDENCE NO. 924 Homestead ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 15 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Augustus J. Rice

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Nellie Leach

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Augustus Rice
(Address) 924 Homestead

15 JUN 22 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1923

17 I HEREBY CERTIFY, That I attended deceased from June 20th 1923, to June 7th 1923, that I last saw h alive on June 7th 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Oedema of Glottis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Stricture Long Throat of
(Complication) Scarlet Fever yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Jacob Hurgotroyd M. D.

6/21/23 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood — DATE OF BURIAL June 22 1923

20 UNDERTAKER Wm Cook — ADDRESS 1001 E Fayette

mation should be carefully supplied. Each question must be answered or the certificate may be properly classified. Especially is this true relative to CAUSE OF DEATH in plain terms, so that it may be properly classified. Each question must be answered or the certificate may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D76923

CERTIFICATE OF DEATH.

31 D76923

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1302 N Chester ST., 8 WARD)

2-FULL NAME Joseph H. Hilditch

(a) RESIDENCE NO. 1302 N. Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Hilditch

6 DATE OF BIRTH (month, day, and year): May 11 – 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer 30

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Thomas H Hilditch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Emily Preston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: George Stanley (Address) 1302 N. Chester St.

15 JUN 22 1925 Filed ....., 19.... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 20 1925

17 I HEREBY CERTIFY, That I attended deceased from March 8 1925 to June 20 1925.

that I last saw h[illegible] alive on June 19th 1925.

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Intra Tubercalosis

(duration) yrs. 6 mos da.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: June 22 1925

20 UNDERTAKER: Wm C. Miller — ADDRESS: 2334 Jefferson

mation should be carefully supplied. Exact information CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76924

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76924

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. ..... ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Shillinger

(a) RESIDENCE NO. St Agnes Hospt ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Public Heath Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto City 048

9 BIRTHPLACE (city or town) ..... (State or country) Pa

PARENTS

10 NAME OF FATHER Samuel Shillinger

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Pa

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Pa

14 Informant (Address) Mrs S Shillinger Lizzie Columbia

15 JUN 22 1923 Robert T. Harrison, .19 ..... Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1923

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1923, to June 21, 1923

that I last saw her alive on June 21, 1923

and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) anaemia Primary?

(duration) 1 yrs.? ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Edward A. Kitlowski, M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Easton Md

DATE OF BURIAL 6/24 1923

20 UNDERTAKER Martin Shake & Son

ADDRESS 1827 N Fulton

mation should be carefully supplied. Exact statement of facts should be given, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76925 117 D76925

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Saint Bells & Hosp. ST., 24 WARD)

2-FULL NAME Rusta Sutch

(a) RESIDENCE NO. 1607½ Covington St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 28 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	16	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier 086

(b) General nature of industry, business, or establishment in which employed (or employer) New Theatre

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Sutch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Berlin

12 MAIDEN NAME OF MOTHER Fannie Caudl.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John Sutch

(Address) 1607½ Covington St.

15 Filed JUN 22 1923, 19 ..... Robert F. Harrison; Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 19 23

17 I HEREBY CERTIFY, That I attended deceased from June 18 19 23 to June 21 19 23

that I last saw h[illegible] alive on June 21 19 23

and that death occurred, on the date stated above, at 1 30 P. M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) Heat prostration

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes: Date of June 20 23.

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) John A. McConnon, M. D.

19 (Address) Saint Bells Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	June 23, 23
20 UNDERTAKER	ADDRESS
Margaret D. Flynn	1422 Light

Information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D76926

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D76926

CERTIFICATE OF DEATH.

12 29

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... William F. Winters

(Residence in Baltimore: No. 2011 Lovegrove Alley .....St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	col	single

6-DATE OF BIRTH. ..... Sept. 21/1912 ..... 1.....
(Month) (Day) (Year)

7-AGE. 10 yrs. 8 mos. 29 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... school boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS

10-NAME OF FATHER. Wm. C. Winters

11-BIRTHPLACE OF FATHER. (State or Country). Md.

12-MAIDEN NAME OF MOTHER. May Jones

13-BIRTHPLACE OF MOTHER. (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) May Winters

(Address) 1116 Bolton St.

15- Robert P. Harrison, Registrar.
192.....
Burial Permit Clerk.

JUN 22 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June 20/23 ....., 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry.....
(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said..... (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tetanus

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) injured lt. knee while at play

.....(Duration).....yrs.....mos.....ds.

(Signed) J. Wade Cole M. D.
(Coroner)

6/23/23 192. (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. St Peter DATE OF BURIAL. June 23 1923

20-UNDERTAKER. Joseph A Farrell ADDRESS 2319 Division

Every item of information should be properly classified. Erasures will void certificate. Be sure to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76927

CERTIFICATE OF DEATH

D76927

REGISTERED NO. 49

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda Thomas.

(a) RESIDENCE NO. 1327 Stockton St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Thomas

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 47. Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

137

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Charles Thomas Sr.

(Address) 1327 Stockton St.

15 Filed JUN 22 1923 19 Robert P. Harrison; Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/20 1923.

17 I HEREBY CERTIFY, That I attended deceased from 6/20 1923. to 6/20 1923.

that I last saw her alive on 6/20 1923.

and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of thyroid.

?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical examin

(Signed) from Bordon M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — DATE OF BURIAL: June 24 1923

20 UNDERTAKER: Joseph A Farrell — ADDRESS: 2317 Druid

Information should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. CAUSE OF DEATH is very important.

Spec.—1-10-21—M&T—1500 Bks.

D76928

HEALTH DEPARTMENT—CITY OF BALTIMORE

X84 D76928

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 7 WARD)

2-FULL NAME Louis Beidl

(a) RESIDENCE No. Darlington ~~ST.~~ WARD S.C.

(Usual place of abode)

Length of residence in city or town where death occurred ~~Unknown~~ How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~: Anna

6 DATE OF BIRTH (month, day, and year): 1879

7 AGE: Years 44 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER Hyman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER Sarah Randall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant (Address): JOHNS HOPKINS HOSPITAL Friends

15 FILED .19 Robert F. Harrison Registrar

JUN 22 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 21st 1923

17 I HEREBY CERTIFY, That I attended deceased from June 19th, 1923 to June 21st, 1923, that I last saw him alive on June 21st, 1923, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor - pachymeningitis hemorrhagica

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of June 20

Was there an autopsy? Partial Autopsy

What test confirmed diagnosis? Operation

(Signed) F. H. Baetjer, M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: DARLINGTON S C

DATE OF BURIAL: 6/22 19 23

20 UNDERTAKER: Jack Lewis

ADDRESS 1437 Eutaw St

mation should be carefully supplied. Exact statement of ... may be properly classified.
CAUSE OF DEATH in plain terms, so that it may ...
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76929

CERTIFICATE OF DEATH.

43 D76929

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2551 W. Lombard St. ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Robison Tall

(a) RESIDENCE NO. 2551 W. Lombard St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E. Tall

6 DATE OF BIRTH (month, day, and year) June 15"1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	41	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Metor Reader for $ 6

(b) General nature of industry, business, or establishment in which employed (or employer) Gas & Electric Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John L. Tall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lydia Swindell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Sarah E. Tall

(Address) 2551 W. Lombard St.

15 NOV 22 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 31, 1923, to June 21, 1923, that I last saw h living live on June 21, 1923, and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Adeno-Carcinoma of Jaw

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Nov. 22nd 1922

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Vernon N. Condon, M. D.

6/22 1923 (Address) 150 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL June 23, 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003 N. Bolton St.

mation should be carefully supplied. Exact statement of occupa-
that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on
ns on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

D76930

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76930

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 735 Newington Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Emma Bell Hampson

(a) RESIDENCE. No. 735 Newington Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 24th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Hampson

11 BIRTHPLACE OF FATHER (city or town) Annapolis
(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret A. L. Erbi

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Edward S. Hampson
(Address) 2702 St. Paul St.

15 Filed JUN 22 1923, 19 Robert P. Harrison
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 21 June 1923

17

I HEREBY CERTIFY, That I attended deceased from 29 May, 1923, to 21 June, 1923, that I last saw h[illegible] alive on 20 June, 1923, and that death occurred, on the date stated above, at 1.40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of L. Ovary

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) — yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam. Consultation. X-Ray

(Signed) Howard W. Bynum M. D.

6/21, 1923 (Address) 749 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	June 23rd 1923
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W. Balto St

mation should be carefully supplied. Exact statement CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76931

CERTIFICATE OF DEATH.

74-001 D76931

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 N Milton ave WARD 6)

2-FULL NAME James Shearan

(a) RESIDENCE. NO. 405 N Milton STR. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kellie Shearan

6 DATE OF BIRTH (month, day, and year) March 4 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Michael Shearan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Erland

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Erland

14 Informant James F. Shearan, Jr (Address) 405 N Milton

15 Filed N 22 1923, 19 Robert P. Harrison; Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1923, to June 21, 1923, that I last saw him alive on June 21, 1923, and that death occurred, on the date stated above, at 10:30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy Hemiplegia Rt.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency Edema Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. G. Geyer, M. D.

, 19 (Address) 541 N. Milton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	June 25 1923
20 UNDERTAKER	ADDRESS
Randall Dysart & Son	378 N

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76932

D76932

CERTIFICATE OF DEATH.

44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Athol- Gate- Frederick Road ST., 28 WARD)

2-FULL NAME Clara Tabb Robertson

(a) RESIDENCE NO. Athol-Gate ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. J. Robertson

6 DATE OF BIRTH (month, day, and year) June 27-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	67	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) Hampton

(State or country) Virginia

PARENTS

10 NAME OF FATHER John Tabb

11 BIRTHPLACE OF FATHER (city or town) Va.

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Malvina Tabb

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Tabb Robertson

(Address) Frederick Road

15 Filed JUN 22 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. , 1923 , to June 21 , 1923 ,

that I last saw h[illegible] alive on June 21 , 1923 ,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Marshall Blrst M. D.

June 22, 1923 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL June 23 1923

20 UNDERTAKER Wm. J. Tackner & Sons

ADDRESS [illegible]

mation should be carefully supplied. Exact statement of occupation CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10 21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76933

D76933

CERTIFICATE OF DEATH. 101-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3321 Edmondson Ave., ST., 20 WARD)

2-FULL NAME William W. Addison,

(a) RESIDENCE NO. 3321 Edmondson Ave., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 91 yrs. 4 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Susannah Addison,

6 DATE OF BIRTH (month, day, and year) January 24 1832

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	91	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Shoe Manufactirer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Samuel S. Addison,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Sarah Morse,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Charles E. Addison.

(Address) 3321 Edmondson Ave.

15 Filed JUN 22 1923. Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUN 22 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1923, to June 22, 1923,

that I last saw him alive on June 21, 1923,

and that death occurred, on the date stated above, at 2:55 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Diffuse Nephritis more than

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic & Bacteriological Exam.

(Signed) Geo. T. Kemp, M. D.

JUN 22 1923 (Address) St. Josephs Apartments

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Mt Olivet DATE OF BURIAL JUN 24 1923

19

20 UNDERTAKER Geo W Little

ADDRESS 2700 EDMONDSON AVE.

mation should be carefully supplied. Exact statement of facts CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

D76934

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76934

1-PLACE OF DEATH

City of BALTIMORE: (No. Fred. Gen. Hosp. St., 27 Ward) Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert E. Mittnacht

(Residence in Baltimore: No. 5217 Elsinore Ave. St.; yrs. 24 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	Single

6-DATE OF BIRTH. June 25 1900
(Month) (Day) (Year)

7-AGE. 19 yrs. 11 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Elevator Boy
(b) General nature of industry, business, or establishment in which employed (or employer) Harper Cotton Co.

9-BIRTHPLACE, (State or Country) Balto. Md.

PARENTS.

10-NAME OF FATHER, B. A. Mittnacht

11-BIRTHPLACE OF FATHER, (State or Country) Balto. Md.

12-MAIDEN NAME OF MOTHER, Ida E. Zerbst

13-BIRTHPLACE OF MOTHER, (State or Country) Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B. A. Mittnacht

(Address) 5217 Elsinore Ave

15-

Filed JUN 23 1923 19.. Robert P. Harrison Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 20 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental injuries to Chest & abdomen
Elevator accident
Exact nature undetermined
(Duration) ....yrs. ....mos. ....ds.
CONTRIBUTORY (Secondary) Elevator accident injuries
(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.
(Coroner.)
June 21 1923 (Address) ?

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn — DATE OF BURIAL. June 23 1923

20-UNDERTAKER. Wm Cook — ADDRESS 502 E North Ave

N. B.—Every item of information should be given, so that it may be properly classified. Exact statement in plain terms, so that it state CAUSE OF DEATH in plain terms, so that it is very important. See instructions on back of certificate.

Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Blks. 10 0051

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76935

CERTIFICATE OF DEATH.

164 D76935

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2723 West North Ave ST. 15 WARD)

2-FULL NAME Emma Frances Kitchenelly

(a) RESIDENCE NO. 2723 W North Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 7 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 3 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Marx

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mita Hielie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elsie Mc Gill

(Address) 2723 w nash ave

15 Filed 3 1923 Robert P. Harrison; Registrar

Burial Permit Clerk.

N 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 23, 1918, to June 21, 1923, that I last saw h alive on June 21, 1923, and that death occurred, on the date stated above, at 4:50 P m.

The CAUSE OF DEATH* was as follows:

Senile Debility

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) G E Buxton, M. D.

6/22, 1923 (Address) 301 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery

DATE OF BURIAL June 23 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 N Mont Ave

mation should be carefully supplied. Exact statement of DEC
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76936 3/D76936

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2002 Penna Ave ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Edna Smith

(a) RESIDENCE NO. 2002 Penna Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colrd	Married

5a If married, widowed, or divorced
(or) WIFE of Edward Smith

6 DATE OF BIRTH (month, day, and year) Oct 19, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	8	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 10
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Nathaniel Powell
11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)
12 MAIDEN NAME OF MOTHER Annie Jackson
13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Julia Carey
(Address) 2002 Pa Ave

15 Filed JUN 23 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1923, to June 21, 1923.
that I last saw h alive on June 20, 1923.
and that death occurred, on the date stated above, at 12:15 P. m.
The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
(Signed) C. William Frey M. D.
6/21 1923 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem
20 UNDERTAKER Daniel Easton

DATE OF BURIAL 6-23 1923
ADDRESS 916 Pa Ave

Information should be carefully supplied. Exact statement of facts must be properly classified. Any CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of facts must be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Any CAUSE OF DEATH is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76937

CERTIFICATE OF DEATH.

100-001 D76937

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1349 N. Stricker St. 15 WARD)

2-FULL NAME James Graham

(a) RESIDENCE NO 1349 N. Stricker ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 2, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER James Graham

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Jennie Lee

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md.
(State or country)

14 Informant Jennie Graham
(Address) 1349 N. Stricker St.

15 Filed JUN 23 1923, 192 Robert P. Harrison Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) no history (duration) yrs. mos. ds.

(Signed) J. T. Hennessy, M. D.
(Coroner)
(Address) 20 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn DATE OF BURIAL June 23 1923

20 UNDERTAKER Wm. H. Chase & Son ADDRESS 1400 Mosher

TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76938

D76938

CERTIFICATE OF DEATH.

31

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 728 Pierce St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel A Hersey

(a) Residence No. 728 Pierce St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 2 49

7-AGE. 74 yrs. 2 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 170

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER, Joseph Cooper

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

11- (Informant) Sarah Timmons

(Address) 728 Pierce St

JUN 23 1923 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 21-23

I HEREBY CERTIFY, That I attended deceased from June 6 1923 to June 21, 1923

that I last saw h.er alive on June 20 1923

and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What lest confirmed diagnosis? No

(Signed) J. Clarence Davies M. D.

6-24 1923 (Address) 753 Vernon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Laurel Elm	June 23 1923
20-UNDERTAKER, Sam V. Cross Wm	ADDRESS 400 Mosher

should be carefully supplied, in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. 4-10-21 M&T 1500 Blks.

D76939

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-00 D76939

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 256 S. Bouldin St., No WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Henry Jolins

(a) RESIDENCE No. 256 S. Bouldin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of Sara Jolins

6 DATE OF BIRTH (month, day, and year) Oct 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Copper. Smelter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

856

9 BIRTHPLACE (city or town) (State or country) Wales

PARENTS

10 NAME OF FATHER David Jolins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Thomas Manuel

(Address) 256 S. Bouldin

15 Robert P. Harrison, .19

Registrar

Burial Permit Clerk.

JN 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1923

17

I HEREBY CERTIFY, That I attended deceased from May 1 1923, to June 21 1923, that I last saw h... alive on June 20 1923, and that death occurred, on the date stated above, at 11:45 A.m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Loos, M. D.

6/24 1923 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem. DATE OF BURIAL June 23 1923

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Pleas...

mation should be carefully supplied. Exact statement of occupa... may be properly classified. CAUSE OF DEATH in plain terms, so that it ma... on back of certificates. TION is very important. See instructions on bac...

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76940 ✓ D76940

CERTIFICATE OF DEATH.

REGISTERED NO. 101-001

1-PLACE OF DEATH: St Joseph's Hospital

CITY OF BALTIMORE: (No. 9 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James V. Hall

(a) RESIDENCE NO. 1513 Lemmon St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. 10 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Catherine A. Hall

6 DATE OF BIRTH (month, day, and year) Aug. 11 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: James P. Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Malone

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mr. James P. Hall

(Address): 422 Valley St

15 Filed: JUN 23 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22 1923

I HEREBY CERTIFY: That I attended deceased from June 18, 1923, to June 22, 1923.

that I last saw h[illegible] alive on June 22, 1923

and that death occurred, on the date stated above, at 9:15 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Lobar pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Schmidt M. D.

19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: June 25 1923

20 UNDERTAKER: Henry Hooch Son — ADDRESS: 1301 E Eager

N. B. ... mation should be carefully supplied. AGE should be properly classified. Exact statement of ... may be ... CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76941

D76941

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 65 S. Pulaski St. WARD)

2-FULL NAME Rose E. Bremsteller

(a) RESIDENCE NO. 65 S. Pulaski ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 19-1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Charles P. Bremsteller

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Rose C. Voelkel

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant (Address) Charles P. Bremsteller 65 S. Pulaski St.

15 JUN 23 1923, 19 Robert F. Harrison, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/22 1923

17 I HEREBY CERTIFY, That I attended deceased from June 5 1923 to June 22 1923.

that I last saw her alive on June 22 1923.

and that death occurred, on the date stated above, at 12 15 P. m.

The CAUSE OF DEATH* was as follows:

Pertussis 17 days

Bronchial Congestion 6 hours

Spasms 3 hrs

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H Hellen Hemming M. D.

6/22/1923 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 23 1923

20 UNDERTAKER George L. Schwartz ADDRESS 201 Fulton Ave.

Be sure that every question is answered. AGE, NATIONALITY and OCCUPATION should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

D76942 HEALTH DEPARTMENT—CITY OF BALTIMORE D76942

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Eleventh & Fayette St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Oscar A. Reynolds

(Residence in Baltimore: No. 905 So. First St ..... St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH Oct 22nd 1873
(Month) (Day) (Year)

7-AGE 49 7 28
yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Inspector in Can Factory
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, N. J. Reynolds

11-BIRTHPLACE OF FATHER, (State or Country), Md

12-MAIDEN NAME OF MOTHER, Sarah Brown

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma R. Reynolds

(Address) 905 So. First St

15- Robert P. Harrison,

Filed JUN 23 1923 192.... Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 20th 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq. mort. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured Aortic Aneurysm — Hemorrhage

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.
(Coroner)

June 22nd 1923 (Address) Curtis Bay, Balto. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Oaklawn Cemetery — DATE OF BURIAL. June 23 1923

20-UNDERTAKER, Zirkler & Zirkler — ADDRESS 1739 E. Eager St

N.B.—Every item of information should be given, so that it may be properly classified. Exact statement of cause of death in plain terms, so that it may be properly classified. Exact statement of cause of certificate. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76943

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76943

CERTIFICATE OF DEATH.

76 100-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3408 Eastern Ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm M. Keiser

(a) Residence No. 3408 Eastern ave St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) ~~Single~~

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec. 29 1922

7-AGE. — yrs. 5 mos. 22 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Herbert W. Keiser

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto, Md.

12-MAIDEN NAME OF MOTHER, Marie Kreamer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto, Md.

14- (Informant) Herbert W. Keiser

(Address) 3408 Eastern Ave.

15- Robert P. Harrison

Filed ..... 192..... Registrar.

JUN 23 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 21-23

17- I HEREBY CERTIFY, That I attended deceased from June 14 1923 to June 21 19 23

that I last saw h~~e~~ alive on June 21 19 23

and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) ..... yrs. ..... mos. 2 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What lest confirmed diagnosis? —

(Signed) John G. Clemm M. D.

June 22. 1923 (Address) 35 W. Potomac St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Bachmans Cemetery

DATE OF BURIAL. June 23 19 23

20-UNDERTAKER, Zinkler & Zinkler

ADDRESS 1739 E. Eager

Should be carefully supplied. Exact statement of occupation is required in plain terms, so that it may be properly classified. Exact statement of cause of death is required in plain terms, so that it may be properly classified. See instructions on back of certificates.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Primary

Spec.—1-10-21—M&T—1500 Bks.

D76944

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76944

CERTIFICATE OF DEATH.

1924

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 N. Castle ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Probst

(a) RESIDENCE NO. 1012 N. Castle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Probst

6 DATE OF BIRTH (month, day, and year) May 3 1858

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
65	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia Europe

PARENTS

10 NAME OF FATHER James Probst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia Europe

12 MAIDEN NAME OF MOTHER Marie Slavick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia Europe

14 Informant Mrs Anna Probst (Address) 1012 N Castle st

15 Filed JUN 23 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1923

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1923, to June 22, 1923, that I last saw him alive on June 22 1923, and that death occurred, on the date stated above, at 6:25 a. m.

The CAUSE OF DEATH* was as follows:

Heat Prostration

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted — If not at place of death? ...

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? ...

(Signed) Edward Swan, M. D.

, 19 (Address) 811 N Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakhill — DATE OF BURIAL June 24 1923

20 UNDERTAKER Burkhart Birkler — ADDRESS 739 Eager

N.B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

m.d.h.

D76945

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76945

CERTIFICATE OF DEATH.

105

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 N. Hoffman ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie E. Wilmer

(a) RESIDENCE NO. 314 N. Hoffman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Caroline Co. Md

PARENTS

10 NAME OF FATHER Robert Wilmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Caroline Co. Md

12 MAIDEN NAME OF MOTHER Charlotte Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Caroline Co. Md

14 Informant Carrie Wright

(Address) Denton Md

15 Filed Robert P. Harrison, Registrar

UN 23 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1923

17

I HEREBY CERTIFY, That I attended deceased from May 15, 1923, to June 22, 1923

that I last saw her alive on June 22, 1923

and that death occurred, on the date stated above, at 10 a m

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Buckler, M. D.

6/22 1923 (Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hillsboro, Md.	June 23, 23
20 UNDERTAKER James H. Wilmer	ADDRESS 303 Druid...

N. B.—WRITE PLAINLY. All questions should be answered. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not Tuberculous

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76946

CERTIFICATE OF DEATH.

D76946

REGISTERED NO. 25 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Reynolds

(a) RESIDENCE NO. St. Agnes' Hospital ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Hospital

(c) Name of employer St. Agnes' Hospital

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thos. Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine Costel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records
(Address) M. T. Harrison

Filed JUN 23 1923 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1923, to June 22, 1923, that I last saw him alive on June 22, 1923, and that death occurred, on the date stated above, at 7.10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia (tuberculous) (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? B. B. Sputum X-ray

(Signed) Harry D. McCurdy M. D.

6-22-23 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL June 25 1923

20 UNDERTAKER Henry W. Jenkins Son

ADDRESS Orchard & Cullen

WRITE information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. MEDICAL CERTIFICATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76947

D76947

CERTIFICATE OF DEATH.

REGISTERED NO. 159.002

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 510 N. Decker Ave. (ST.) (WARD) 7 (Rockett)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Brockelle

(a) RESIDENCE NO. 510 N. Decker Ave. ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): 9. 2. 22.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. md.

PARENTS

10 NAME OF FATHER: Thomas Brockelle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hartford Conn.

12 MAIDEN NAME OF MOTHER: Ida M. Fastner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Thomas Brockelle 510 N. Decker ave.

15 [illegible] 19 Robert P. Harrison, Registrar

JUN 23 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6. 22. 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 23 1923 to June 23 1923

that I last saw her alive on June 23 1923

and that death occurred, on the date stated above, at 5:00 P. m.

The CAUSE OF DEATH* was as follows:

Excessive Heat

(duration) yrs. mos. ds.

Congenital Heart Disease (duration) yrs. 9 mos. 20 ds.

CONTRIBUTORY (secondary)

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What was confirmed diagnosis? Clinical

(Signed) Charles H. A. Meyer M. D.

6/22/23 (Address) 1031 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 23 1923
20 UNDERTAKER	ADDRESS
Mendel [illegible] Sons	37 Sams

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76948

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76948

CERTIFICATE OF DEATH.

16 X 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2429 Harlem Ave. ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Rue Brown

(a) RESIDENCE NO. 2429 Harlem Ave. ST., WARD Pimlico Pa.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of T. Boswood Brown

6 DATE OF BIRTH (month, day, and year) Feb. 12" 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia

(State or country) Pa.

PARENTS

10 NAME OF FATHER Henry M. Rue

11 BIRTHPLACE OF FATHER (city or town) Phila.

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Ida Van Dyke

13 BIRTHPLACE OF MOTHER (city or town) Hopwell

(State or country) N. J.

14 Informant M.H. Quinn & T.B. Brown

(Address) Mayo Md. A. A. Co.

15 Filed ..... 19 ..... Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 28 1916 to June 21 1923

that I last saw her alive on June 21 1923

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pericarditis, ascites, uraemia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical & urinalysis Blood examination

(Signed) John A. Fleischer M. D.

6/22, 19 23 (Address) 1025 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	June 23, 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Bolton St

N. B.—Information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76949

CERTIFICATE OF DEATH.

14-001 D76949

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 N. Calhoun St. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rebecca Duvall

(a) RESIDENCE NO. 822 N. Calhoun St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 22" 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	9	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Edward Duvall

11 BIRTHPLACE OF FATHER (city or town) Prince Geor
(State or country) Md.

12 MAIDEN NAME OF MOTHER Adeline Duvall

13 BIRTHPLACE OF MOTHER (city or town) A.A.Co.
(State or country) Md.

14 Informant John W. Hodges
(Address) 822 N. Calhoun St.

15 Robert P. Harrison, Registrar

JUN 23 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1923

17 I HEREBY CERTIFY, That I attended deceased from June 21 , 1923 , to June 22- , 1923 .

that I last saw him alive on June 22- , 1923 ,

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. L. McCardell M. D.

6/22 1923 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	June 25 1923
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 N. Paca St.

F. B.—Information should be carefully supplied. Age should be correctly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. DEATH is very important.

Spec.—1-10-21—M&T—1500 Blks.

D76950

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76950

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST., 129 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara E. Tieke

(a) RESIDENCE NO. 823 S. Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced, ~~HUSBAND~~ of (or) WIFE of late Emil Tieke

6 DATE OF BIRTH (month, day, and year) May 30/70

7 AGE — Years: 53 Months: 0 Days: 21 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Lottie Saunders

(Address) 2014 Orleans St

15 Filed ..... 19 ..... Registrar

Robert F. Harrison, Burial Permit Clerk.

JUN 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1923

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1923, to June 21, 1923, that I last saw h... alive on June 21, 1923, and that death occurred, on the date stated above, at 4 A, m.

The CAUSE OF DEATH* was as follows:

Uremic Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Clinical

(Signed) A Thomas, M. D.

Mar 27 1923 (Address) 1228 E Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL 6/23 1923

20 UNDERTAKER: Philip Hennig — ADDRESS 2016 Orleans

B—WHITE should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76951

CERTIFICATE OF DEATH.

188-00 D76951

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. In front of 130 W. Hamburg ST., 23 WARD)

2-FULL NAME William R. Manifold.

(a) RESIDENCE NO. Deals Md. ST., ... WARD Deals Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed or divorced
XXXXXXXXXX
XXXXXXXXXX
XXXXXXXXXX

6 DATE OF BIRTH (month, day, and year) May 8, 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	1	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... None.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Deals Md.

PARENTS

10 NAME OF FATHER William H. Manifold.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Deals Md.

12 MAIDEN NAME OF MOTHER Lena Rogers.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Deals Md.

14 Informant Lena Manifold. (mother).
(Address) Deals Md.

15 Filed JUN 23 1923, 192... Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Automobile Accident.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

June 23, 1923 (Address) 101 E. Chadles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Herring Creek Cem aab	June 23 1923
20 UNDERTAKER	ADDRESS
A. Howard Evans	428 E. Chas St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every certificate. TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76952

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76952

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Burr

(a) Residence No. 628 N. Bruce St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1860

7-AGE. 62 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer): 0

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. Henry Burr

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Louise Davis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Municipal Hospital Records

(Address)

15- Robert P. Harrison, Registrar.

JUN 23 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 21, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 18 1923 to June 21 1923 that I last saw him alive on June 20 1923 and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (Degenerative)
Myocardial Insufficiency

(Duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) ..... yrs. 1 mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Goldsmith M. D.

6-21-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Bel Aubum Cem. DATE OF BURIAL. June 23 1923

20-UNDERTAKER. B. G. Gross ADDRESS 1700 E. Eldersly st

should be carefully supplied. Exact statement of OCCUPATIONS necessary, in plain terms, so that it may be properly classified. For instructions on back of certificates.

D76953

HEALTH DEPARTMENT—CITY OF BALTIMORE D76953

D76953

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Homewood Hospital St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Williams

(Residence in Baltimore: No. 2013 N. Charles St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, July (Month) 17 (Day) 1892 (Year)

7-AGE, 31 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Chauffer
(b) General nature of Industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country) Md

PARENTS.

10-NAME OF FATHER, Henry Williams

11-BIRTHPLACE OF FATHER, (State or Country) Balto Md

12-MAIDEN NAME OF MOTHER, Amanda Hasbrook

13-BIRTHPLACE OF MOTHER, (State or Country) Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Amanda Amass

(Address) 2310 E. Cook St

15- Robert F. Harrison

Registrar.

JUN 23 1923

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 22 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull

Caused by Falling from Car

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. J. Morrissey M. D.
(Coroner)

June 22 1923. (Address) 232 E. Cook St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, June 25 1923

20-UNDERTAKER, SHENOWETH & SON,

ADDRESS 2617 CHESTNUT AVE.

B.—Every item of information should be carefully worked out, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... certificate. is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Hall 1617 E. N. Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76954

D76954

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2515 E. Madison St., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura Virginia Thomas

(a) RESIDENCE NO. 2515 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sr John Thomas

6 DATE OF BIRTH (month, day, and year) July 26 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Chas Henry Lang

11 BIRTHPLACE OF FATHER (city or town) Canada
(State or country)

12 MAIDEN NAME OF MOTHER Mary Jane Dillon

13 BIRTHPLACE OF MOTHER (city or town) Washington D.C.
(State or country)

14 Informant Miss Paula Ferdinands
(Address) 2515 E. Madison

15 Filed JUN 23 1923 Robert F. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1923

17 I HEREBY CERTIFY, That I attended deceased from June 20 - 1923 to June 22 1923

that I last saw her alive on June 20 - 1923

and that death occurred, on the date stated above, at 7-2 m.

The CAUSE OF DEATH* was as follows:

Hemi-plegia -

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Arterio - Sclerosis -

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) C. Gill Hall M. D.

June 22 1923 (Address) 1617 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	June 25 - 19
20 UNDERTAKER	ADDRESS
Wm Cook	602 E. Balto St

B.—WRITE PLAINLY with pen and ink. AGE should be carefully supplied. Exact statement of ... mation should be carefully supplied. AGE should be stated ... it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be ... on back of certificates. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic

D76955

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D76955

1-PLACE OF DEATH

City of BALTIMORE: (No. ~~437 W~~ Mercy Hospital Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Noah Bradley

(Residence in Baltimore: No. 437 Pentzella St St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Col.	Married

6-DATE OF BIRTH, Unknown ....., 1..... (Month) (Day) (Year)

7-AGE, 5-7 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Laborer
(b) General nature of Industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. H. Sidney Bradley

(Address) 1116 Chew

15-

Filed JN 23 1923

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 19 23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an McGinn (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said McGinn (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

Duration (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. Riley M. D. (Coroner)

June 22 1923 (Address) 1639 Bond

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Mt Zion Ct June 24 1923

20-UNDERTAKER. ADDRESS.

J. B. Brown & Son 108 W. Monument

B.—Every item of information must be given, so that it may be properly classified. Cross out words not applicable. Do not state CAUSE OF DEATH in plain terms, so that it may be properly classified. Cross out words not applicable. Do not is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76956

CERTIFICATE OF DEATH.

113 D76956

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1417 Mulliken ST., 5 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Bowman

(a) RESIDENCE NO. 1417 Mulliken ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Sept 12- 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ✓

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): md.

PARENTS

10 NAME OF FATHER: Keith Gaines

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington D.C.

12 MAIDEN NAME OF MOTHER: Sarah Bowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington D.C.

14 Informant: Sarah Bowman (Address) 1417 Mulliken St.

15 Filed JUN 23 1923, 19 ..... Registrar

Robert P. Harrison;
Burial Permit Clerk.

B.—WRITE PLAINLY, with ink or indelible pencil. AGE should be stated EXACTLY. Information should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 21, 1923

17 I HEREBY CERTIFY, That I attended deceased from 6/10, 1923, to 6/21, 1923.

that I last saw h[illegible] alive on June 20, 1923

and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

"Gastro-enteritis"

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Intestinal Colic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? No Date of. . .

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jacob Robinson M.D.

(Address) 1520 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetary	June 23 1923
20 UNDERTAKER	ADDRESS
Joseph T.H. Rochester	1139 Jefferson

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76957

CERTIFICATE OF DEATH.

101-001 ✓ D76957

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 413 E 23 dd St., 12 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Marrison

(a) RESIDENCE No. 413 E 23 dd St., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J. A. Morrison.

6 DATE OF BIRTH (month, day, and year): 1873

7 AGE: Years 50 | Months . | Days . | If LESS than 1 day, hrs. or min. .

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 1 10

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ohio.

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio.

14 Informant: J. A. Morrison Jr.

(Address): 415 E Twenty Third St.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 21st 1923

17

I HEREBY CERTIFY, That I attended deceased from June 11, 1923, to June 21, 1923.

That I last saw her alive on June 21, 1923.

and that death occurred, on the date stated above, at 11:10 A m.

The CAUSE OF DEATH* was as follows:

Edema Pneumonia and complications (acute Pleurisy)

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary): General Weakness

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Ed. L. Ball, M. D.

, 19 (Address) 423 E 23d St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 25 1923
20 UNDERTAKER	ADDRESS
Mrs. A. G. Elliott	2[illegible] Eutaw

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificate. This is very important.

JUN 23 1923

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1923 6 5

D76958 8

D76958

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 N. Dallas ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Lee

(a) RESIDENCE. No. 1209 N. Dallas ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo Lee

6 DATE OF BIRTH (month, day, and year) May 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	0		

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Geo Lee

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Parks

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Annie Hammond

(Address) 1209 N. Dallas St.

15 Filed ..... 19.... Robert F. Harrison Registrar

JUN 23 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-22- 1923

17 I HEREBY CERTIFY, That I attended deceased from 4-12-, 1923, to 6-22-, 1923, that I last saw h.. alive on 6-21-, 1923, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. H. Haagill M. D.

6-23-1923 (Address) 611 N. Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn M E Cemetery	June 24 1923
20 UNDERTAKER	ADDRESS
Barnes & Co	1364 Mc Cay

CAUSE OF DEATH must be stated plainly. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76959

D76959

CERTIFICATE OF DEATH.

1924

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 505 Bloom ST., 14 WARD)

2-FULL NAME Robert Gate

(a) RESIDENCE NO. 505 Bloom ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 31 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Robert Gate

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Sadie Emory

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant Sadie Emory
(Address) 506 Bloom St

15 Filed JUN 23 1923 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1923

17 I HEREBY CERTIFY, That I attended deceased from June 22 to 1923 . 19 .

that I last saw h alive on June 22 , 1923 .

and that death occurred, on the date stated above, at 4:30 pm

The CAUSE OF DEATH was as follows:

Exposure heat Prostration

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Coleman M. D.

, 19 (Address) 2034 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: B.M.Z. DATE OF BURIAL: June 24 1923

20 UNDERTAKER: Barnes Billingsley & Co ADDRESS

B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important.

Cor.—1-12-23—M&T—100 Bks.

D76960

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76960

CERTIFICATE OF DEATH.

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Curtis Bay off East Brook ST., 25 WARD)

2-FULL NAME Edward L. English.

(a) RESIDENCE No. Wilmington N.C. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ___ ___ ___ ___ ___

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about	40	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Deck hand Tug

(b) General nature of industry, business, or establishment in which employed (or employer) Margaret.

(c) Name of employer Clarence Cottman Co.

9 BIRTHPLACE (city or town) (State or country) Do not know.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Police Report.

(Address)

15 Filed ..... 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1928. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Probable Suicide, Temporary aberration (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

June 28. 192 (Address) 1012 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilmington N.C. via U.S. Express	June 23 192 3

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D76961

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 D76961

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 808 Peach Alley. ST., 22 WARD)

2-FULL NAME James Taylor. C.

(a) RESIDENCE NO. 808 Peach Alley ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Richmond, Va.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Do not know.

14 Informant Fannie Bates. (C)
(Address) 518 W. Conway St.

15 Filed JUN 23 1923 Burial Permit Check.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17th, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

June 21, 192 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL
UNIVERSITY OF MARYLAND, Undertaker Holt
Rec. Wm. E. Woodall

DATE OF BURIAL
192

20 UNDERTAKER .....
ADDRESS .....

JUN 23 1923

THE MORGUE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D76962 **HEALTH DEPARTMENT—CITY OF BALTIMORE** ✓

CERTIFICATE OF DEATH.

31 D76962

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2128 Mmis ST. 13 WARD)

2-FULL NAME Sarah Blackwell

(a) RESIDENCE NO 2128 Morris ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Blackwell

6 DATE OF BIRTH (month, day, and year) about 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) (General)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mary Charles
(Address) 2128 Morris St.

15 Filed JUN 23 1923 Robert F. Heyliger, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) H. C. Hemmeter M. D.
(Coroner.)

June 24, 1923 (Address) 2503 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND. DATE OF BURIAL JUN 23 1923

20 UNDERTAKER Commissioner Health ADDRESS

Wm. F. Woodall

JUN 23 1923 OF THE MORGUE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation and cause of death is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76963

CERTIFICATE OF DEATH.

128 D76963

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 Barre alley ST., 18 WARD)

2-FULL NAME Mary Johnson

(a) RESIDENCE NO. 813 Barre alley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Launders
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer from Washington D C

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) " "
(State or country) "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country)

14 Informant Adel Brown
(Address) 830 Robert St.

15 Filed ..... 192.. ..... Registrar

UN 23 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 192 3

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest, autopsy or~~ inquiry.) thereon and from the evidence obtained by said ~~inquest, autopsy or~~ inquiry.) find that said deceased came ~~to~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. K. Lynch, M. D.
(Coroner.)

6-22-, 1923 (Address) 117 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL June 24 192 3

ADDRESS 124

20 UNDERTAKER Brown & Shepard

Registered according to the Ordinances of Baltimore City. Exact statement of OCCUPATION must be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. INFORMATION is very important.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76964

CERTIFICATE OF DEATH.

X 197 D76964

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt. Gen. Hosp. ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Smith

(a) RESIDENCE NO 1211 Whatcoat ST., WARD N. Carolina
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benj. F. Smith First time married this time

6 DATE OF BIRTH (month, day, and year) About 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) Private
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER Benj. J. Fredrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Minnie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Carolina

14 Informant Benj. J. Fredrick (Address) 1211 Whatcoat

15 Filed UN 23 1923 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said au- (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wound in back. (Shot by her husband)

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Homicide

(duration) yrs. mos. ds.

(Signed) J. J. F. Kennedy, M. D.
(Coroner.)

June 23, 1923 (Address) 2502 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence N. Carolina

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Ridge Cemetery DATE OF BURIAL 6/23 1923

20 UNDERTAKER James H. Bernard ADDRESS 3003 Fleetwood

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CAUSA-TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76965

CERTIFICATE OF DEATH.

31

D76965

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 Jordan ST.: 11 WARD)

2-FULL NAME Harry Wells

(a) RESIDENCE. No. 909 Jordan ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 12, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	19	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter in Store 110

(b) General nature of industry, business, or establishment in which employed (or employer) Electric fixtures

(c) Name of employer Union Electric Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

19 NAME OF FATHER Walter Wells

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Dorsey

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mrs. Mary Wells

(Address) 909 Jordan St.

15 Filed JUN 24 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1923 to June 21, 1923 that I last saw him alive on June 21, 1923 and that death occurred, on the date stated above, at 12.20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) — yrs. 7 mos. — ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. N. Pettibone M. D.

. 19 (Address) 817 Hamilton Ter.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	6/24 1923
20 UNDERTAKER J. H. Toadvine	ADDRESS 142 W. Hill St

N. B.—WRITE PLAINLY, with ink. All items must be supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied

Spec.—1-10-21—M&T—1500 Blks.

1643 64 D76966

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D76966

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

2-FULL NAME Calvin Parker Jr.

(a) RESIDENCE NO. 710 N. Point ST., WARD City
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH CORRECT SPELLING. All information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 7, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
			16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Calvin Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ethel Augustus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address) Friends

15 Filed JUN 24 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1923

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1923, to June 23, 1923, that I last saw him alive on June 23, 1923, and that death occurred, on the date stated above, at 3 32 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) X (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes. —

What test confirmed diagnosis?

(Signed) R. A. Wreck, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem | DATE OF BURIAL 6/24 1923

20 UNDERTAKER Jno H Joachim | ADDRESS 14 W Hill

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76967

CERTIFICATE OF DEATH.

161-001 D76967

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 317 Fort Hill St.: 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Milke

(a) RESIDENCE. No. 317 Fort Hill St., 20 Ward.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 1/2 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) June 22-23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
				12

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Christopher Milke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Helen Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Chas. Milke 317 Fort Hill

15 Filed ... 19... ROBERT R. KRAUTER, Registrar

JUN 24 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1923

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1923, to June 23, 1923, that I last saw her alive on June 23, 1923, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. A. Krull, M. D.

6/23, 1923 (Address) Irvington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	June 24 1923
20 UNDERTAKER Geo. J. Smith	ADDRESS 532 Holliday

N. B.—WRITE plainly with pen and ink. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76968

CERTIFICATE OF DEATH.

9 D76968

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2719 Greenmount St., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvia E. Wagner

(a) RESIDENCE No. 2719 Greenmount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 23 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2		

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City (State or country)

PARENTS

10 NAME OF FATHER Wm Frainer

11 BIRTHPLACE OF FATHER (city or town) City (State or country)

12 MAIDEN NAME OF MOTHER Amil Turner

13 BIRTHPLACE OF MOTHER (city or town) Penna (State or country)

14 Informant Amil Turner (Address) 2719 Greenmount Ave

15 Filed JUN 24 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to June 23, 1923, that I last saw h[illegible] alive on June 22, 1923, and that death occurred, on the date stated above, at 7 AM m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. C. Haber, M. D.

6-23, 1923 (Address) 5200 York Rd. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 6/24 1923

ADDRESS

20 UNDERTAKER W J Sutherland & Sons Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. PHYSICIAN'S ... should be stated EXACTLY. Physician's ... mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION of deceased should be made. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D76969

Schwartz

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 D76969

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Schwartz.

(a) Residence No. 1708 W Lexington St. Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of J. E. Schwartz

6-DATE OF BIRTH (month, day and year) Apr 5-1888

7-AGE. 35 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, William T. Ford.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Lucy Forder

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) J. E. Schwartz

(Address) 1708 W. Lexington

15- FILED JUN 24 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-22-23

17- I HEREBY CERTIFY, That I attended deceased from 6-18 1923 to 6-22 1923

that I last saw h alive on 6 22 1923

and that death occurred, on the date stated above, at 2.30 P. M.

The CAUSE OF DEATH* was as follows:

old appendicial abscess. ruptured pelvic adhesions

(Duration) 1 yrs. mos. ds.

CONTRIBITORY (Secondary) Sec. q. Shock.

(Duration) yrs. mos.

18-Where was disease contracted if not at place of death? Abdominal pelvic

Did an operation precede death? Yes Date of 6-22-23

Was there an autopsy? No

What test confirmed diagnosis? Symptoms Signs

(Signed) W. J. Finnegan M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL, June 25, 1923

20-UNDERTAKER. Wm. J. Tickner Son

ADDRESS N. Y. Pa.

N. B.—WHITE Labels should be carefully supplied. AGE should be stated EXACTLY. Physician's certificate of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76970

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76970

CERTIFICATE OF DEATH.

45

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 27 S. Edw ST., 3 WARD)

2-FULL NAME Sophia Singer

(a) RESIDENCE No. 27 S. Edw ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? 18 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Singer

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Wolf Singer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rebecca —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) J. Lewis 1439 E. Balto.

15 Filed JUN 24 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1923.

17 I HEREBY CERTIFY, that I attended deceased from Sept 21, 1922 to June 22, 1923.

that I last saw h alive on June 22, 1923.

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Retroperitoneal sarcoma

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 1922 JHH.

Was there an autopsy? No

What teat confirmed diagnosis? Operation

(Signed) Arthur C Peterson M. D.

6/23 1923 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arlington Wash Road	June 24 1923
20 UNDERTAKER	ADDRESS
Fact Lewis.	1439 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76971

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D76971

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2233 Eutaw Place ST., 13 WARD)

2-FULL NAME Abner Hoff

(a) RESIDENCE NO. 2233 Eutaw Place ST., 8 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (Write the word)
M	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lipsa Hoff

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Mordie Hoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Baily Rood

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant May Hoff

(Address) 2233 Eutaw Place

15 JUN 24 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1923

17

I HEREBY CERTIFY, That I attended deceased from June 23, 1923, to June 23, 1923, that I last saw him alive on June 23 1923, and that death occurred, on the date stated above, at 3 30 9 m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? observation.

(Signed) Joseph E Gichner M. D.

(Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew, Herring Run	June 24 1923

20 UNDERTAKER Far. Levine, 1439 E. Balto ADDRESS

Thiman

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76972

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76972

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3501 Greenspring Ave (St.) (Ward) 32

2-FULL NAME Katie Thiman

(a) RESIDENCE. No. 3501 Greenspring Ave St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4-1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	11	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Saleslady
(b) General nature of industry, business, or establishment in which employed (or employer) Dept Store
(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) (State or country) Jacob Thiman

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia
12 MAIDEN NAME OF MOTHER Rebecca Lazarus
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) 1739 Bucks St. Lewis

15 Filed JUN 24 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 4 1922 to June 23 1923
that I last saw her alive on June 23 1923
and that death occurred, on the date stated above, at 5.55 p. m.
The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis.

about (duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Usual

(Signed) B M Bergamt M. D.
6 23 1923 (Address) 3451 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Hebrew Rosedale June 24 23

20 UNDERTAKER — ADDRESS
Jacot Lewis, 1439 E. Balto

A. B. C. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76973

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-001 D76973

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hosp. ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Gelblum

(a) RESIDENCE NO. 724 N Gay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W-Jewish	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Louis Jacobson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rachel Linder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant E. Gelblum

(Address) 724 N Gay st

15 JUN 24 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/23 1923

17 I HEREBY CERTIFY, That I attended deceased from May 26 1923, to June 23 1923, that I last saw h.e alive on June 23 1923 and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. 1 mos. 26 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 24 1923

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Soder Sydney Leuner, M. D.

6/23 1923 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	6/24 1923
20 UNDERTAKER Sol Spivack & Bro	ADDRESS 1127 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be carefully supplied. PHYSICIANS should state mation should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76974

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 D76974

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Boy Hospital

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

2-FULL NAME Ada Levin

(a) RESIDENCE NO. 706 N. Fulton Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE OF Melvin H. Levin

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE: Years 39. Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): None
(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Adolph Moritz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Boy Hospital
(Address): Baltimore, Md.

15 JUN 24 1923 ROBERT B. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22 1923

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1923, to June 22, 1923
that I last saw h alive on June 21, 1923
and that death occurred, on the date stated above, at 7:10 A. m.
The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Lueto Conjection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) A. Feldmeth, M. D.

, 19 (Address) Boy Hospital Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 6/26 1923

20 UNDERTAKER: Martin Bagley Co — ADDRESS: 1821 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76975

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76975

CERTIFICATE OF DEATH.

O.K. 41 H.K. 9 Gorsch

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

2-FULL NAME Dallam Allen

(a) RESIDENCE NO. 3647 Chestnut Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 9 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Oct 5 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	9	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrician
(b) General nature of industry, business, or establishment in which employed (or employer) General Elec Co
(c) Name of employer " " "

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Walter S Allen

11 BIRTHPLACE OF FATHER (city or town) Dayton (State or country) Ohio

12 MAIDEN NAME OF MOTHER Mary E. Dallam

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Walter S. Allen
(Address) 3647 Chestnut Ave

15 JUN 24 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1923

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1923, to June 22, 1923, that I last saw him alive on June 22, 1923 and that death occurred, on the date stated above, at 7.35 P. m.

The CAUSE OF DEATH* was as follows:

Streptococcus Septicemia (duration) yrs. mos 9 ds.

CONTRIBUTORY (secondary) Laceration left thumb (duration) yrs. mos 10 ds.

18 Where was disease contracted if not at place of death? University Hospital

Did an operation precede death? yes Date of June 15, 23

Was there an autopsy? no

What test confirmed diagnosis? Blood culture

(Signed) M J Hanna M. D.

19 (Address) 1522 N Fremont to St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	June 25 1923
21 UNDERTAKER Wm J Tickner & Sons	ADDRESS N Y Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76976

CERTIFICATE OF DEATH.

7H-001 D76976

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 N. Bruce St., ST. 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Simms

(a) RESIDENCE NO 1021 N. Bruce St. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Simms.

6 DATE OF BIRTH (month, day, and year) March 11, 1879

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
44	3	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home Duties
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) West River, Md,
(State or country)

PARENTS

10 NAME OF FATHER Jacob Simms

11 BIRTHPLACE OF FATHER (city or town) Md,
(State or country)

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) Don't Know,
(State or country)

14 Informant Mary Thomas
(Address) 1021 N. Bruce St.

15 Filed JUN 24 1923 192 ROBERT B. KRAUT Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) no history.

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner)

June 23. 1923 (Address) 210 E. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL June 25 1923

20 UNDERTAKER Samuel W. Case & Son — ADDRESS 1400 Mosher

♦CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bln.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76977

CERTIFICATE OF DEATH.

74-001 V

REGISTERED NO. C D76977

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Warwick Jut Hopkins ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane Williams

(Residence in Baltimore: No. Warwick Jut Hopkins St. 50 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. ACCURATE and COMPLETE. Information is very important. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, ... (Month) ..... (Day) ..... (Year) 1856

7-AGE, 67 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER, Lucinda Boston

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Lee

(Address) Warwick & Jut Hopkins

15- JUN 24 1923 ROBERT R. KRAMER Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 22 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 12 — 1923, to June 22 1923, that I saw h[illegible] alive on June 21 — 1923, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows: Right Hemiplegia

..... (Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Coleman M.D.

Jun 22, 1923 (Address) 1039 N. Caroline

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Zion — DATE OF BURIAL, 6/5/23

20-UNDERTAKER, Caldwell & Hundley — ADDRESS 938 E Baltimore

Remarks Cerebral Haemorrhage

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*). For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion." "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion,	*Cellulitis,*	*Childbirth,*	*Convulsions,*
Hæmorrhage,	*Gastritis,*	*Erysipelas,*	*Meningitis,*
Gangrene,	*Miscarriage,*	*Necrosis,*	*Peritonitis,*
Phlebitis,	*Pyæmia,*	*Septicæmia,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76978

CERTIFICATE OF DEATH.

90 D76978

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 713 S. Second St. ST.; 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Streit

(a) RESIDENCE. No. 713 S. Second ST., 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., If of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Streit

6 DATE OF BIRTH (month, day, and year) Sept 11 - 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	9.	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Car inspector

(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R. R. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER John Streit

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant Louisa Streit.
(Address) 713 S. Second St.

JUN 24 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 2 1923. to June 22 1923.
that I last saw him alive on June 1 - 1923.
and that death occurred, on the date stated above, at 10.30 a. m.
The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia 4 days

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis? Sky Examination

(Signed) Geo Clinton Black M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	June. 25 1923
20 UNDERTAKER: Lilly and Zeiler	ADDRESS: 403 S. Broadway

N. B.—WRITE PLAINLY WITH UNFADING INK. All items should be stated EXACTLY. PHYSICIANS should be careful to see that information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76979

CERTIFICATE OF DEATH.

129 D76979
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Sheridan

(a) Residence No. 1507 E. Chase St. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1869

7-AGE. 53 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

837

9-BIRTHPLACE (city or town) (State or Country), New York

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country).

11- (Informant) Municipal Hospital Records
(Address)

13- FILED JUN 24 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 22, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 21 19 23 to June 22 19 23
that I last saw her alive on June 22 19 23
and that death occurred, on the date stated above, at 1:20 P.M.

The CAUSE OF DEATH* was as follows:
Chronic interstitial Nephritis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia
(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N. Goldsmith M. D
6-23-1923 Address Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Baltimore County	June 25 1923
20-UNDERTAKER. Robt S Turner Jnr	ADDRESS 1412 N Broadway

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76980 ✓ D76980

CERTIFICATE OF DEATH.

REGISTERED NO. C 56

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1907 Division ST.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret F Kerr

(Residence in Baltimore: No. 1907 Division St.; 1 yrs., 6 mos. 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F | 4-COLOR OR RACE, Colored | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Jan 7, 1922 (Month) (Day) (Year)

7-AGE, 1 yrs. 6 mos. 15 ds. | If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Com Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, T. Henderson Kerr

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Geneva Tyler

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. Henderson Kerr

(Address) 1907 Division St

15- JUN 24 1923 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 22, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 20 1923, to June 22 1923, that I saw h er alive on June 22 1923, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Rachitis

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Convulsions 3 hrs

(Duration) yrs. mos. ds.

(Signed) H. S. McCard M. D.

6/23, 1923 (Address) 2005 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem | DATE OF BURIAL, June 25 1923

20-UNDERTAKER George T. Gibbons | ADDRESS 513 Fairmount Ave

N. B.—Every item of information should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIAN must fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76981

CERTIFICATE OF DEATH.

90 D76981

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2550 W. Fairmount Ave St. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie A. Clark.

(a) RESIDENCE NO. 2550 W. Fairmount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 10 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be stated EXACTLY. mation should be carefully supplied. that it may be properly classified. CAUSE OF DEATH in plain terms, so Exact statement of OCCUPATION is very important. See instructions ons on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Richard Clark.

6 DATE OF BIRTH (month, day, and year) July 28, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	46	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Duties

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Eliza acton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash. D. C.

12 MAIDEN NAME OF MOTHER Julia A. McCleary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Camilla M. Hartlet

(Address) 2550 W. Fairmount Ave

15 Filed JUN 24 1923, 19

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1923, to June 22, 1923, that I last saw her alive on June 22, 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease —
(Interstitial Myocarditis)

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Acute arthritis

(duration) — yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No Physical Laboratory findings

What test confirmed diagnosis?

(Signed) H. M. Harrison, M. D.

June 23 1923 (Address) 1733 N. Charles Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL June 25 1923.

20 UNDERTAKER Mr. Mrs. John N. Teufel & Son — ADDRESS 801 N. Fayette St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76982 ✓ D76982

D76982

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital ST., 17 WARD)

2-FULL NAME Mrs Joanna Gibson.

(a) RESIDENCE NO. 406 E. 20 St. Balto. Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 6 mos. 25 ds. How long in U. S., if of foreign birth? 68 yrs. 6 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	W.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 28. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68 yrs.	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER William Gorman

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Denn.

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Miss Millie Gibson
(Address) 405. E. 26 St. Balto.

15 JUN 24 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1923

17 I HEREBY CERTIFY, That I attended deceased from 6/6 1922, to 6/23 1923, that I last saw her alive on 6/22 1923, and that death occurred, on the date stated above, at 7 30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
(arterio-sclerosis). (from Senility).

(duration) 1 yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Edward A. Kutlowski, M. D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL June 25 1923

20 UNDERTAKER Harry W. Ehlen — ADDRESS 1948 W. Northern

N. B.—WRITE PLAINLY, WITH UNFADING INK. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D76983

CERTIFICATE OF DEATH.

90 D76983

1-PLACE OF DEATH St. Mary's Industrial School REGISTERED NO. C

CITY OF BALTIMORE: (NO. Wilkens ave & Pulaski ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Mulvany

(Residence in Baltimore: No. St. Mary's Industrial School, St.; Lifetime yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If unknown, a reasonable approximate should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Unknown (Month) (Day), 1864 (Year)

7-AGE, 59 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Driver
(b) General nature of industry, business, or establishment in which employed (or employer) St. Mary's Ind. School

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bro. Paul

(Address) St. Mary's Ind. School

15- JUN 24 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 22, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 15 1922, to June 22 1923, that I saw h[illegible] alive on June 21 1923, and that death occurred, on the date stated above, at 6. [illegible] m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Chronic Myocarditis with

decompensation

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pul-Tuberculosis

(Duration) yrs. 1½ mos. ds.

(Signed) J. T. Mecca M. D.

6/22, 1923. (Address) 804 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St. Vincents Cemetery

DATE OF BURIAL, June 25 1923

20-UNDERTAKER Chas. F. Evans & Son

ADDRESS 1118 North Eutaw

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D76984

CERTIFICATE OF DEATH. X 31 D76984

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1026 McCulloh ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Virginia

2-FULL NAME Ambus Hinkefield

(a) RESIDENCE No. 1026 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS RECORD must be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be p TION is very important. See instructions on back of c

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Charlotte Hinkefield

6 DATE OF BIRTH (month, day, and year) March 9, 1869

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brunetteville Va

PARENTS

10 NAME OF FATHER Henry Hinkefield

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) "

14 Informant, Henry Hinkefield (Address) 1026 McCulloh St

15 Filed JUN 24 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22. 1923

17 I HEREBY CERTIFY, That I attended deceased from June 9th, 1923, to June 22nd, 1923, that I last saw him alive on June 19th, 1923, and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Hemorrhoids

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? N. C.

Did an operation precede death? No Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) H. Lee Chis M. D.

6/22, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 6-25 1923

20 UNDERTAKER Daniel Easton

ADDRESS 916 Pa ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76985

CERTIFICATE OF DEATH.

113 D76985

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1000 Falls Rd. ST., 13 WARD)

2-FULL NAME Thomas L. Clark

(a) RESIDENCE NO. 1000 Falls Rd. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wh	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 27, '23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Servant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Clarence E. Clark

11 BIRTHPLACE OF FATHER (city or town) Savage (State or country) Md.

12 MAIDEN NAME OF MOTHER Ruby Rawson

13 BIRTHPLACE OF MOTHER (city or town) Havre de Grace (State or country) Md.

14 Informant Clarence E. Clark (Address) 1000 Falls Road

15 Filed JUN 24 1923, 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1923

17

I HEREBY CERTIFY, That I attended deceased from 6/21, 1923, to 6/23, 1923, that I last saw him alive on 6/23, 1923 and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Geo. E. Hoff, M. D.

6/23 1923 Address) 20 20 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
St. Mary's (Hampden)	June 25 1923
20 UNDERTAKER	ADDRESS
Horace H. Burgee	363 Falls Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be stated EXACTLY. PHYSICIANS should state AGE, should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks. 38765

D76986

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

58-001 D76986

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2060 E Hoffman St.; 8 WARD)

2-FULL NAME Cyrus Franklin Thomas

(a) RESIDENCE. No. 2060 E Hoffman St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store-keeper Confectionery

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery etc

(c) Name of employer Self.

9 BIRTHPLACE (City or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John F Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Ellen Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Paul S. Thomas

(Address) Williamstown Md

15 JUN 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 19 23

17

I HEREBY CERTIFY, That I attended deceased from May 9th, 19 23, to June 24, 19 23,

that I last saw h— alive on June 2, 19 23,

and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

, 1923 (Address) 720 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frederick Md	June 28 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W Balto St.

N. B.—WRITE PLAINLY. WITH UNFADING INK. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D76987

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-002 D76987

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE. (No. St Joseph's Hospital D WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John ~~Lassick~~ John Lassich

(a) RESIDENCE NO. 110 Albemarle St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: M. Lassich

6 DATE OF BIRTH (month, day, and year): June 30/1883

7 AGE: Years 39 Months Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: John Lassick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant: Mrs M. Lassich

(Address): 110 Albemarle st.

15 JUN 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 23 1923

17

I HEREBY CERTIFY, That I attended deceased from June 22, 1923, to June 23, 1923, that I last saw him alive on June 23, 1923, and that death occurred, on the date stated above, at 5 10a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Intes Lind Obst-ruction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/22/23

Was there an autopsy? Yes Date of 6/23/23

What test confirmed diagnosis?

(Signed) S. W. Kramer, M. D.

, 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent Cemetery — DATE OF BURIAL: June 25 1923

20 UNDERTAKER: George J. Rush — ADDRESS: 1735 Harford ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76988

CERTIFICATE OF DEATH.

1885 D76988
REGISTERED NO. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 1632 Linden ave ST.) (WARD) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 2.)

2-FULL NAME Wm. W. Lockey (Widower)

(Residence in Baltimore: No. 1632 Linden ave. 68 yrs., — mos. — ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male.

4-COLOR OR RACE. White

5-~~SINGLE, MARRIED, WIDOWED, OR DIVORCED,~~ (Write the word.) Married

6-DATE OF BIRTH. Oct 14 / 1881 (Month) (Day), 1881 (Year)

7-AGE, 42 yrs. 8 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Candy Business
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Maryland.

PARENTS.

10-NAME OF FATHER. Mordicai G. Lockey.

11-BIRTHPLACE OF FATHER (State or Country) Maryland.

12-MAIDEN NAME OF MOTHER Mary Slade

13-BIRTHPLACE OF MOTHER (State or Country) Balto County

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Lora Lockey

(Address) 1632 Linden ave

15-

Filed ....., 191.... ROBERT R. KRAUTER, Registrar.

JUN 25 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... January 22, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~inquest~~ autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) ~~jury~~ find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull (Accidental)

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) acute meningitis

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) J. T. Hennessy M. D.
(Coroner.)

Jan 25, 1923 (Address) 2. E. Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge

DATE OF BURIAL, June 25 1923

20-UNDERTAKER J. E. Mitchell

ADDRESS 201 W Fayette

Spec.—1-10-21—M&T—1500 Bks.

D76989

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76989

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No. Lafayette & John ST. 2. 15 WARD) 16-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Klein

(a) RESIDENCE NO. 4033 Bonnar Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1 day	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Woman's Hospital Balto. Md.

PARENTS

10 NAME OF FATHER Jacob S. Klein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Yaffe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Jacob S. Klein

(Address) 4033 Bonnar Rd. Balto. Md.

JUN 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1923

17

I HEREBY CERTIFY, That I attended deceased from June 23, 1923, to June 24, 1923, that I last saw him alive on June 24, 1923, and that death occurred, on the date stated above, at 5 38 P. m.

The CAUSE OF DEATH* was as follows:

Probable Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) J. Ogle Warfield, Jr. M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fisher's Wash Road — DATE OF BURIAL: June 25 1923

20 UNDERTAKER: Jack Ellis — ADDRESS: 1799 E Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Injury at birth

Moravetz.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D76990

D76990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 N Monford ave ST.; WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Maravetz

(a) RESIDENCE. No. 1616 E Eager ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Emil Maravetz

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia Bamberg

PARENTS

10 NAME OF FATHER Leopold Metzel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bamberg

14 Informant Marty Benesch

(Address) 701 N Franford ave

JUN 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6—24 1923

17 I HEREBY CERTIFY, That I attended deceased from August 21, 1922, to June 24, 1923

that I last saw h[illegible] alive on June 24, 1923

and that death occurred, on the date stated above, at 3.A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation Diabetes

Arterio Sclerosis Hypertension

Gastritis Ulcer (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.

(Address) 1601 N Mont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	June 26 1923
20 UNDERTAKER	ADDRESS
J. Ahrens & Co	1611 Mad ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D76991 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D76991

CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH — Registered No. .....

City of BALTIMORE: (No. Municipal Hospital St., 19 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Duvall

(a) Residence No. 1707 Wilkens Ave St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine? A. Duvall

6-DATE OF BIRTH (month, day and year) Aug. 15th 1853

7-AGE. 69 yrs. 10 mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Fireman (B & O.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) A. A. County Md.

PARENTS:

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Mary Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

Unable to obtain history.

14- (Informant) Municipal Hospital Records
(Address) Baltimore, Md.

JUN 25 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 23, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 20 19 23 to June 23 19 23
that I last saw him alive on June 22 19 23
and that death occurred, on the date stated above, at 2:00 A M
The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(Duration) — yrs. 3 mos. — ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) N. Gresomith M. D

6-23-23 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. June 26th 1923

20-UNDERTAKER. Joseph B. Cook ADDRESS 1003 N. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D76992

D76992

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: NO. ..... ST., 24 WARD)

2-FULL NAME Mrs Rebneider

(a) RESIDENCE NO. 1618 Orbotee ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Schneider

6 DATE OF BIRTH (month, day, and year) 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist Helper

(b) General nature of industry, business, or establishment in which employed (or employer) Riverside (B & O.R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Bay View Hospital (Address) Balto. Md.

15 Filed JUN 25 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 12 1923 to June 23 1923

that I last saw h— alive on June 22 1923

and that death occurred, on the date stated above, at 7.10 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (terminal)

..... (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. H. Edginton M. D.

6/23 1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Clan Hill Cem	June 26 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76993

CERTIFICATE OF DEATH.

43

REGISTERED NO. D76993

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3003 Brighton ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin P. Link

(a) RESIDENCE NO. 3003 Brighton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daisy M. Link

6 DATE OF BIRTH (month, day, and year) 5/16/1865

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
57	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md.

PARENTS

10 NAME OF FATHER Eliza Link

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md.

12 MAIDEN NAME OF MOTHER Sheldon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co Md

14 Informant Daisy M Link

(Address) 3003 Brighton St

15 JUN 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1923.

17

I HEREBY CERTIFY, That I attended deceased from May 14, 1923, to June 22, 1923.

that I last saw him alive on June 22 1923.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Malignant Cachexia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? yes Date of Sept 1922.

Was there an autopsy? no

What test confirmed diagnosis? Examination of

(Signed) John S. Thalard M. D.

6/25, 1923 (Address) 1219 Aisquith Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	6/25 1923

20 UNDERTAKER George J Ruth ADDRESS 1135 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76994 D76994

CERTIFICATE OF DEATH.

120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 E. Biddle street, ST. 10 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Creszentia Hempel,

(Residence in Baltimore: No. 1213 E. Biddle street, St.; 63 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female,

4-COLOR OR RACE, White,

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, May 30th, 1840.
(Month) (Day) (Year)

7-AGE, 83 yrs. 0 mos. 24 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None,
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Germany,

PARENTS.

10-NAME OF FATHER, John Raiber,

11-BIRTHPLACE OF FATHER (State or Country), Germany,

12-MAIDEN NAME OF MOTHER Josephine Kopp,

13-BIRTHPLACE OF MOTHER (State or Country), Germany,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Amelia Hempel, daughter,

(Address) 1213 E. Biddle street.

15- JUN 25 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 24th (Day), 1923. (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 8th, 1923, to June 24th, 1923, that I saw her alive on June 24th, 1923, and that death occurred, on the date stated above, at 3.10 pm

The CAUSE OF DEATH* was as follows:

Acute Yellow Atrophy Of Liver,

(Duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Senility.

(Duration) 20 yrs. mos. ds.

(Signed) J. Frederick Hempel M. D.

June 24th 1923. (Address) 3310 N. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem DATE OF BURIAL, 6/27/23 1917

20-UNDERTAKER Stewart & Mowen Co ADDRESS 108 W North Ave
W. J. Worden Successor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76995

CERTIFICATE OF DEATH.

1/3 D76995

1-PLACE OF DEATH

City of BALTIMORE: (No. 300 N Chapel St., W Ward)

Registered No.....

2-FULL NAME Infant Magdalene Jenkins

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 300 N Chapel St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6-DATE OF BIRTH (month, day and year) Nov 9 1922

7-AGE. ....yrs. 7 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General natnre of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Maryland

PARENTS.

10-NAME OF FATHER, John Jenkins

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Louisa Everett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) John Jenkins

(Address) 300 N Chapel St

15- JUN 25 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 22, 23

17- I HEREBY CERTIFY, That I attended deceased from June 21 19 23 to June 22 19 23

that I last saw h alive on June 22 19 3

and that death occurred, on the date stated above, at 10 30 P.m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Enteritis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? Phy Exam

What test confirmed diagnosis? Phy Exam

Dr. Geo Clinton Blade M. D.

(Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mount Carmel	June 25 1923
20-UNDERTAKER.	ADDRESS
Wendell J Hoppe	37 S Canal

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D76996

D76996

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 Wellesley ST., 20 WARD)

2-FULL NAME Annie Eckarius

(a) RESIDENCE NO. 536 Wellesley ST., 20 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Fred Eckarius

6 DATE OF BIRTH (month, day, and year) Apr 5/1868

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
55	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Baltimore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Emma Dorsey

(Address) 315 Johnson Ave

JUN 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1 1923 to June 22 1923, that I last saw her alive on June 21 1923 and that death occurred, on the date stated above, at 3 40 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 5 yrs. mos da

CONTRIBUTORY (Secondary) Chr. Int. Nephritis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) W A Keel, M. D.

6/25/1923 (Address) Loudon Co

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL June 25 1923

20 UNDERTAKER C. W. Dill — ADDRESS 3109 Frdk Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76997

CERTIFICATE OF DEATH.

31 ✓ D76997

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... St., Municipal Tuberculosis Hospital WARD) 19

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William O. Wright

(a) RESIDENCE No. 1703 Frederick ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet maker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. O. Wright

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Harriett Wolford

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant ..... (Address) Hospital Records

ROBERT R. KRAUTER,
Burial Permit Clerk.

15 JUN 25 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1923

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1923, to June 22, 1923, that I last saw him alive on June 22, 1923, and that death occurred, on the date stated above, at 11.45 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Harold McCarty, M. D.

6-23-23 19 (Address) Municipal Tbc Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 26, 19 23
20 UNDERTAKER George J. Smith	ADDRESS 1253 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D76998

CERTIFICATE OF DEATH.

41 D76998

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 Valleyview Ave. Ridgecroft Rd. ST. 27 WARD)

2-FULL NAME Elmer J. Williams

(a) RESIDENCE No. 20 Ridgecroft Ave. Ridgecroft Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 9 mos. 5 ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of ~~(or WIFE of)~~ Gertrude M. Williams

6 DATE OF BIRTH (month, day, and year) Sept. 18 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Optician

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Jacob P. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Etzel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs. Gertrude M. Williams

(Address) 20 Ridgecroft Ave

15 Filed JUN 25 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1923

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1923, to June 23, 1923, that I last saw h[illegible] alive on June 23, 1923, and that death occurred, on the date stated above, at 10:- P. m.

The CAUSE OF DEATH* was as follows:

Acute General Sepsis
(probably Streptococcic)

(duration) yrs. mos 1½ ds.

CONTRIBUTORY (Secondary) acute Glossitis & Stomatitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm R. Geraghty, M. D.

6/24 1923 (Address) 203 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 19 26
20 UNDERTAKER	ADDRESS
Henry Hoeck & Son	1301 E Eager St

Spec.—8-24-14—M. & T.—2000 Bks.

D76999

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D76999

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1061 Argyle Ave St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas E Griffin

(Residence in Baltimore: No. 1061 Argyle Ave St.; Life yrs. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
M	C	Married

6-DATE OF BIRTH, ? (Month) ? (Day) 17 (Year)

7-AGE, approx 70 yrs mos da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, John Griffin

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary Mitchell

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Leonora Griffith

(Address) 1061 Argyle Ave

15- JUN 25 1923 ROBERT R. KRAUTER, Registrar.

Filed ..... 191.... Burial Permit .....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 22 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1922, to June 22 1923, that I saw him alive on June 21 1923, and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(Duration) yrs. 8 mos. da.

CONTRIBUTORY (Secondary) Myocarditis & Hypertrophy

(Duration) yrs. mos. da.

(Signed) R J Young M. D.

6/22, 1923 (Address) 1424 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Laurel County	June 25 1923
20-UNDERTAKER	ADDRESS
Theodore T White	118 Gough St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D77000 HEALTH DEPARTMENT—CITY OF BALTIMORE D77000

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3102 Ellerslie Ave ST., 9 WARD)

REGISTERED NO. 109002

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Charles Carrick

(a) RESIDENCE NO. 3102 Ellerslie Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White. | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 30 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	0	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER James B. Carrick

11 BIRTHPLACE OF FATHER (city or town) Belmont Co. (State or country) Ohio.

12 MAIDEN NAME OF MOTHER Gertrude J. Kirk

13 BIRTHPLACE OF MOTHER (city or town) Pittsburg (State or country) Pa.

14 Informant James Carrick (Address) 3102 Ellerslie Ave

15 Filed JUN 25 1923 ROBERT R. KRAMER Registrar. Assist. Deputy Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 22nd 1923 to June 24th 1923.

that I last saw him alive on June 24th 1923,

and that death occurred, on the date stated above, at 8.05 a m.

The CAUSE OF DEATH* was as follows:

Vincents Angina

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam.

(Signed) Geo W Humphrey M.D. M. D.

(Address) 401 E 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL June 25 1923

20 UNDERTAKER E A Wiedefeld Jr — ADDRESS 501 E 22nd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Culture negative for Dip.

Spec.—1-10-21—M&T—1500 Bks.

D77001

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77001

43

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1917 Ramsey St. W. WARD)

2-FULL NAME Budget Burns.

(a) RESIDENCE NO. 1917 Ramsey St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Martin Burns

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Conroy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Martin Gilmore (Address) 1917 Ramsey St.

15 JUN 25 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1923.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1923, to June 23, 1923, that I last saw her alive on .. .. , 1923 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Tongue.
Chronic Endocarditis

(duration) ..... yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) ..... yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Chas V. Carolahan M. D.

6/25, 1923 (Address) 24 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. John's Cathedral	June 26 1923
20 UNDERTAKER John J. Conaughton	ADDRESS 701 Hollins St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D77002

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X188-007 D77002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 14 WARD)

2-FULL NAME Chas. W. McCoy

(a) RESIDENCE NO. Forland Bather Mc ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 1 ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Elmer E. McCoy

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Magnolia Swingley

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Harvey Hay
(Address) Forland Md

15 JUN 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed Skull. Struck from Motor Cycle

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) ... yrs. 4 hours

(Signed) W. K. Gonaghey, M. D.
(Coroner.)

6/26, 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem Md — DATE OF BURIAL 6/26 1923

20 UNDERTAKER W J Tutman's Sons — ADDRESS Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. mation should be properly classified. so that it may be properly classified. CAUSE OF DEATH in plain terms, Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77003

CERTIFICATE OF DEATH.

31 D77003

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 915

CITY OF BALTIMORE, No. 915 N. Fremont Ave (WARD) 16

2-FULL NAME Frederick E. Allen

(a) RESIDENCE No. 915 N. Fremont Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day, and year): April 17-22

7 AGE — Years: 1 — Months: 2 — Days: 6 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Jas. L. Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Janie Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: James E. Allen

(Address): 915 N. Fremont Ave

15 JUN 25 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22 1923

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1923 to June 22, 1923

that I last saw him alive on June 22, 1923

and that death occurred, on the date stated above, at 11-30 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Toxemia-Pneumonia.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Asthenia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical diagnosis

(Signed) W. F. Carr, Jr. M. D.

(Address) 815 Mosher St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rest Lawn Cem. DATE OF BURIAL: 6/26/23

20 UNDERTAKER: Frank E. Kennedy ADDRESS: 5 W Biddle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77004 47 D77004

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 James St ST.: 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Salchunas

(a) RESIDENCE. NO. 1310 James St ST., 21 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60 Yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER Noknow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Noknow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant A.Hube

(Address) 1310 James Street

15 Filed JUN 25 1923 19 ROBERT R. KRAUTH, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1923

17 I HEREBY CERTIFY, That I attended deceased from June 20 , 1923 , to June 23 , 1923 , that I last saw her alive on June 22 , 1923 , and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Carcenoma of Breast

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Heat Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of March 1922

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) [signature] M. D.

6.26. 19 (Address) 517 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 26th 1923

20 UNDERTAKER ADDRESS

John Grebliauckas J.G. 425 S Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. F. Co.—1000 Bks.

D77005

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77005

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3534 Edmondson Ave ST.: 16 WARD)

2-FULL NAME Frida Reinecke

(a) RESIDENCE. No. 3534 Edmondson Ave ST.: WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 72 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	w	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Henry Reinecke

6 DATE OF BIRTH (month, day, and year) 10-15-1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
78	78	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Voight

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorch.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) daughter 3534 Edmondson

15 Filed JUN 25 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 21st 1923, to June 24th 1923, that I last saw h alive on June 24th 1923, and that death occurred, on the date stated above, at 10:15 P m

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Dementia, Cutaneous Ulcers

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Benj. D McCleary, M. D.

6/25, 1923 (Address) 400 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 26 1923
20 UNDERTAKER	ADDRESS 1203
D Henry Lutz	N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77006

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77006

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST., 9 WARD)

2-FULL NAME Infant Ludwig

(a) RESIDENCE NO. 1530 E 28th ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
[illegible]				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Harold Elwin Ludwig

11 BIRTHPLACE OF FATHER (city or town) Boots
(State or country)

12 MAIDEN NAME OF MOTHER Pearl Corbin Clarke

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant .....
(Address)

15 JUN 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1923

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1923, to June 24, 1923,

that I last saw h[illegible] alive on June 24, 19....,

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Premature birth

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

6/24, 1923 (Signed) J. Kimzey, M. D.

(Address) 2700 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	
20 UNDERTAKER	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S NOTIFICATION of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

199

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77007

CERTIFICATE OF DEATH.

46 D77007

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1112 Homewood Ave WARD) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jeanette Sindall

(a) RESIDENCE NO. 1112 Homewood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 19 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	75	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER David Sindall

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Jane Conway

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs. Nagle
(Address) 1112 Homewood Ave

15 Robert E. Harrison, M.D. 19 Registrar

JUN 25 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 6, 1923, to June 23, 1923,

that I last saw her alive on June 22, 1923,

and that death occurred, on the date stated above, at 5:00 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus
Contusion

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) Unknown yrs. mos. da.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) J. Lewis Bevan M.D.

6/24/23 (Address) 2848 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Govans — DATE OF BURIAL June 26 1923

20 UNDERTAKER J. C. Bradfield — ADDRESS 914 Greenmount Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION on back of CAUSE OF DEATH is very important. See instructions on back of certificate.

MARGIN RESERVED

Spec.—1-10-21—M&T—1500 Bks.

D77008 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D77008

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 621 St Anns Ave. ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Purnell Brittingham.

(a) RESIDENCE No. 621 St. Anns Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. 9 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Wonder Brittingham,

6 DATE OF BIRTH (month, day, and year) Sept 11, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Car Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) Penn. Rail Road.

(c) Name of employer (Pennsylvania R.R.)

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Brittingham

11 BIRTHPLACE OF FATHER (city or town) Worcester Co.,
(State or country) Md. Maryland.

12 MAIDEN NAME OF MOTHER Anne Smithson

13 BIRTHPLACE OF MOTHER (City or town) Worcester Co.
(State or country) Md.

14 Informant Wife Florence W. Brittingham
(Address) 621 St. Anns Ave.

15 Filed , 19 Robert F. Harrison, Registrar
Burial Permit Clerk.

JUN 25 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1923. to June 23, 1923.
that I last saw him alive on June 23, 1923.
and that death occurred, on the date stated above, at 11 44 P m.
The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis
(duration) 0 yrs. 3 mos ds.
CONTRIBUTORY (Secondary) Hypertension + Arterio Sclerosis
(duration) 1 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urinalysis

(Signed) Henry F. Buettner M. D.

. 19 (Address) 1273 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	July 26 23
20 UNDERTAKER	ADDRESS
Ehrenwerth & Lee	Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

O.D.A.K.

Spec.—1-10-21—M&T—1500 Bks.

D77009

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77009

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1916 Linden Ave ST. 14 WARD)

2-FULL NAME Catherine Jenkins

(a) RESIDENCE NO. 1916 Linden Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 77 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) England

PARENTS

10 NAME OF FATHER Jenkins

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) England

12 MAIDEN NAME OF MOTHER Jenkins

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Mrs. Marcus
(Address) 916 Linden

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

JUN 25 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1923

17 I HEREBY CERTIFY, That I attended deceased from June 8, 19..... to June 23 19 23.
that I last saw her alive on June 21, 19 23
and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) William Fries, M. D.

6/25. 1923 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 25 1923

20 UNDERTAKER Mushin Tuckey & Sons ADDRESS 1820 W North

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77010 D77010

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 526 E North ave ST.: 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James W. Jenkins

(a) RESIDENCE No. 526 E North ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 13 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer: Mt Vernon Buck Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James W. Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Kennedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Mrs J. Lenkins 526 E. North Ave

15 Filed JUN 25 1923 19 Robert P. Harrison, Registrar

(Signature of Burial Permit Clerk)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 23

17 I HEREBY CERTIFY, That I attended deceased from July 15 1921 to June 19 23

that I last saw h alive on June 24 1923.

and that death occurred, on the date stated above, at 1.20 p.m.

The CAUSE OF DEATH* was as follows:

Atro Sclerosis
Cerebral Hemorrhage

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. Thomas, M. D.

June 25 19 23 (Address) 1228 N Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	June 27 1923
20 UNDERTAKER	ADDRESS
E A Wiedefeld & Son	501 E 22 St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONTRIBUTORY is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77011

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77011

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp'l ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Maiers

(a) RESIDENCE NO. 440 Pinkney Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Maiers

6 DATE OF BIRTH (month, day, and year) Feb 29-1857

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
~~77~~ 72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Emil Kraus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Emil Kraus

12 MAIDEN NAME OF MOTHER Emil Kraus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Emil Kraus

14 Informant Barbara A. Maiers (Address) 440 Pinkney Place

15 Filed JUN 25 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1923, to June 24, 1923, that I last saw him alive on June 23, 1923, and that death occurred, on the date stated above, at 2 20 A.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? S. & S.

(Signed) John J. Kiger, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	June 26 1923

20 UNDERTAKER Wm Cook 602 E. Fayette ADDRESS

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Clarina Arnold)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77012 ✓ D77012

CERTIFICATE OF DEATH.

123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen Hospital ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Clarine Arnold.

(a) RESIDENCE NO. 1630 John ST. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of George H Arnold

6 DATE OF BIRTH (month, day, and year) June 7, 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs or ... min.
64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Joseph Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant George H Arnold

(Address) 1630 John St

15 Filed ..., 19... Robert P. Harrison, Registrar

JUN 25 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-23-23

17 I HEREBY CERTIFY, That I attended deceased from 6-23-23 to 6-23-23.

that I last saw h[illegible] alive on 6-23-23

and that death occurred, on the date stated above, at 6 10 P m.

The CAUSE OF DEATH* was as follows:

Abd Embolism

(duration) yrs. mos 2 hrs

CONTRIBUTORY (Secondary) Chronic Cholecystitis

Cholelithiasis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6-2-23

Was there an autopsy? Cholecystotomy,

What test confirmed diagnosis? Clinical & Operation

(Signed) Jno A Tompkins, M. D.

, 19 (Address) 1630 Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 6/26 1923

20 UNDERTAKER William Cook

ADDRESS 502 E Nay

MARGIN RESERVED FOR BINDING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—

Spec.—1-10-21—M&T—1500 Blks.

D16,4506
D16,013 12 15 P.M

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77013

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital. 6 WARD

CITY OF BALTIMORE: (No. ..... ST., WARD)

REGISTERED NO. 9

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harold Chase

(a) RESIDENCE NO. 425 N. Dunham St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 22, 1923.

7 AGE — Years: — Months: 2 Days: 30 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Thomas Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mabel Chase

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: JOHNS HOPKINS HOSPITAL (Address)

15 Filed ... 19 ... Registrar: Robert P. Harrison;

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 18 . 1923. to June 21 . 1923. that I last saw him alive on June 21 . 1923 and that death occurred, on the date stated above, at 12 10 P. m.

The CAUSE OF DEATH* was as follows:

Pertussis

3 weeks.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ... yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) A. A. Weech, M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL

20 UNDERTAKER: Commissioner Health.

JUN 25 1923

JUN 25 19

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D77014 HEALTH DEPARTMENT—CITY OF BALTIMORE D77014

CERTIFICATE OF DEATH. X 32

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME NICOLA ORSETTA

(Residence in Baltimore: No. Havre de Grace& Md. St.; yrs. ..... mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Single

6-DATE OF BIRTH. July 5, 1922, 1.....
(Month) (Day) (Year)

7-AGE. ....yrs. 11 mos. 20 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Havre de Grace Md.

PARENTS.

10-NAME OF FATHER, Saturno Orsetta

11-BIRTHPLACE OF FATHER, (State or Country). Italy

12-MAIDEN NAME OF MOTHER, Mary Mareno

13-BIRTHPLACE OF MOTHER, (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Saturno Orsetta

(Address) Havre de Grace Md.

15-

Filed JUN 25 1923 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 25/23, 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

.....

.....

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....(Duration).....yrs.....mos.....ds.

(Signed) J. S. Walker M. D.
(Coroner.)

6/25/23 192.. (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Havre de Grace Md. DATE OF BURIAL June 28 19 23

20-UNDERTAKER. H E Hughes ADDRESS 424 N Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Favour)

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77015

CERTIFICATE OF DEATH.

44

D77015

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 1027 N. Fawcett ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Favour

(a) RESIDENCE. No. 1027 N. Fawcett ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-18-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Barlow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Arinna Baylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant J. B. Melton
(Address) 1027 N. Fawcett St

15 Filed JUN 25 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/24 1923

17 I HEREBY CERTIFY, That I attended deceased from 2/7, 1923 to 6/24, 1923

that I last saw h[illegible] alive on 6/24/23

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver.

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob Brown M. D.

. 19 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount View Cemetery	June 26 1923

20 UNDERTAKER Howard Co. Md. ADDRESS

James R. Weer Sykesville Md

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D77016

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77016

57

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospl. St. Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry J. Sandman.

(a) RESIDENCE No. 726 E. Preston St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margt L. Sandman

6 DATE OF BIRTH (month, day, and year) June 1-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	—	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ragpicker. Master

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Jewish C.C.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Samuel Sandman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Berfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Alice Sandman

(Address) 726 E. Preston St.

15 Filed JUN 25 1923 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1923, to June 23 1923, that I last saw him alive on June 23, 1923, and that death occurred, on the date stated above, at 1.10 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John J. Krager, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 6/27/23 19

20 UNDERTAKER Chas. P. Evans & Son

ADDRESS 1181 W. Baltimore St. Royal Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77017

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77017

CERTIFICATE OF DEATH.

Registered No. 10

1-PLACE OF DEATH

City of BALTIMORE: (No. 3110 Oakfield Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola B. Holmes

(a) Residence No. 3110 Oakfield Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 18, 1896

7-AGE: 27 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: Rozier L. Bowis

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Maryland

12-MAIDEN NAME OF MOTHER: Lilly B. DeLaphana

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Maryland

14- (Informant): Rozier L. Bowis

(Address) 3110 Oakfield Ave

15-

Filed JUN 25 1923 Robert P. Harrison; Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 25, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 14, 1923 to June 25, 1923

that I last saw her alive on June 24, 1923

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis 1 minute

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) K. C. Mahet M. D

June 25, 1923 (Address) 1903 W. North Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: June 26, 1923

20-UNDERTAKER: George J. Smith

ADDRESS 153 [illegible] Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

I do not know duration of the disease as it was a neglected case when I made my first visit which was 10 da ago.

R. C. Metzger

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77018 D77018

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 824 West Mosher St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Waltz

(Residence in Baltimore: No. 824 West Mosher St.; yrs. 54 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Married

6-DATE OF BIRTH, Nov 1, 1869 (Month) (Day) (Year)

7-AGE, 54 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Book keeper
(b) General nature of industry, business, or establishment in which employed (or employer) Produce Co

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER Jacob Waltz

11-BIRTHPLACE OF FATHER (State or Country) Md

12-MAIDEN NAME OF MOTHER Catherine Polp

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Margaret Waltz (Informant)

824 W. Mosher (Address)

15-

Filed ....., 191.... Registrar.

5 1923 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 24, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Hemmeter M. D. (Coroner.)

June 25, 1923 (Address) 2327 Eutaw Pl.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge

DATE OF BURIAL, June 27, 1923

20-UNDERTAKER Wm Cook

ADDRESS 502 N Gay

D 77019

Rpec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77019

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1731 N. Mt. Duncan ST., WARD)

2-FULL NAME Carrie Conger

(a) RESIDENCE NO. 1731 Duncan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed or divorced (or) WIFE of Theodore Conger

6 DATE OF BIRTH (month, day, and year) 2-22-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Rahway N.J.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Bertha Hynes

(Address) 1731 N. Duncan

15 Filed JN 25 1923, 19 Robert F. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 - 23

17 I HEREBY CERTIFY, That I attended deceased from Jn 23, 1923, to Jn 26, 1923.

that I last saw her alive on , 19

and that death occurred, on the date stated above, at 1:35 a.m.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) John W. Henderson, M. D.

, 19 (Address) 1714 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 BURIAL, CREMATION OR REMOVAL Patterson

20 UNDERTAKER Wm C

MARGIN RESERVED FOR BINDING

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77020

Spec. 1-10-21—M&T—1500 Bks.

164473

HEALTH DEPARTMENT—CITY OF BALTIMORE

4.05 P.M. X 44 ✓ D77020

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Wilson Heinley

(a) RESIDENCE No. W. 16th St. Tyrone ST. Pa. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Emma. same address

6 DATE OF BIRTH (month, day, and year): 1868

7 AGE — Years: 54 — Months: — Days: — If LESS than 1 day, hrs. or ... min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Paper Mill.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: Beemille Heinley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Catherine Seidel.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant (Address): JOHNS HOPKINS HOSPITAL. ROBERT B. KRAUTER, Burial Permit Clerk

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1923.

17

I HEREBY CERTIFY, That I attended deceased from June 16, 1923, to June 24, 1923:

that I last saw him alive on June 24, 1923.

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolus following bladder resection

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Operation

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of June 17, 1923

Was there an autopsy? yes

What test confirmed diagnosis? .....

(Signed) Albert Blalock, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Tyrone, Pa.

DATE OF BURIAL: 6/26/ 1923

20 UNDERTAKER: E. J. Fanning Hon-1938 E. Lafayette Ave

ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77021

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1113 D77021

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 785 Mulberry ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jas. Edwd Dutton

(a) RESIDENCE NO. 785 Mulberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Col	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sep. 14 1922

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	9 ~~mo.~~	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Geo. E. Dutton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Leam

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant George E. Dutton
(Address) 785 Mulberry St

15 Filed JUN 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1923

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1923, to June 25, 1923, that I last saw ~~deceased~~ alive on June 25, 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Ac. Gastro Enteritis

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Heart.

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clin. Symptoms.

(Signed) Hans E. Hagner M. D.

6/25, 1923 (Address) 1116 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	6-26 1923
20 UNDERTAKER David Easton	ADDRESS 916 Pa ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77022

CERTIFICATE OF DEATH.

57 D77022

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., WARD)

2-FULL NAME Edward A. Leiben

(a) RESIDENCE NO. 513 S. Chapel St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 23 1909

7 AGE	Years	Months	Days	If LESS than 1 day, or ... hrs.
	13	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Ambrose Leiben

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Mary Lentz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Ambrose Leiben
(Address) 513 S Chapel

15 JUN 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1923. to June 25, 1923.
that I last saw him alive on June 25, 1923,
and that death occurred, on the date stated above, at 10.40 A.M.
The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P.S. & S.

(Signed) John J. Krager, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	June 28 1923
20 UNDERTAKER	ADDRESS
Wendell Dippel & Son	378 Nms

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Bialek

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77023

CERTIFICATE OF DEATH.

D77023

1-PLACE OF DEATH

City of BALTIMORE: (No. 623 S Montford St., 1 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Thelma H. Bialek

(Residence in Baltimore: No. 623 S Montford St.; yrs.,.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH. July 1 (Month) (Day) 1920 (Year)

7-AGE, 2 yrs. 11 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). 1736 Gough st Balto Md.

PARENTS.

10-NAME OF FATHER. Frank J. Bialek

11-BIRTHPLACE OF FATHER, (State or Country) Baltimore Md.

12-MAIDEN NAME OF MOTHER. Bessy Hannon

13-BIRTHPLACE OF MOTHER, (State or Country) Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank J. Bialek

(Address) 623 S Montford

15-

FILED JUN 26 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 24 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ends cardiac Pneumonia

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) ....yrs. mos. 2 ds.

(Signed) G. C. Hailes M. D.
(Coroner)

June 25 1923 (Address) 1436 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Holy Rosary Cem DATE OF BURIAL. June 27 1923

20-UNDERTAKER. Frederick W. Ozarowski ADDRESS. Eastern Av

Spec.—1-10-21—M&T—1500 Bks.

D77024

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D77024

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 852 E. 35 St., 12 Ward)

2-FULL NAME Anna A. Engle

(a) RESIDENCE No. 852 E. 35 St Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47/15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Engle

6 DATE OF BIRTH (month, day, and year): Mar 5 1846

7 AGE — Years: 76 — Months: 3 — Days: 19 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: Daniel E Engle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Isabella Shaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant (Address): Mrs Kennedy (Daughter) 852 E. 35 St

15 Filed JUN 26 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1923

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1923, to June 24, 1923, that I last saw h[illegible] alive on June 24, 1923, and that death occurred, on the date stated above, at 12.50 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry E Kerr M. D.

(Address) 36 W Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cooleville Md — DATE OF BURIAL: June 27 1923

20 UNDERTAKER: A S Marshall — ADDRESS: 3539 Falls Rd

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D77025

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

182 D77025

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 504 N.Brice St. St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertha A.Behrendt

(Residence in Baltimore: No. 504 N.Brice St. St. [redacted] 7 mos. 29 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. October (Month) 26 (Day) 1922 (Year)

7-AGE. [redacted] yrs. 7 mes. 29 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... (none)
(b) General nature of industry, business, or establishment in which employed (or employer) ..... (Infant)

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Albert K.Behrendt

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Sophia Miller

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert K.Behrendt

(Address) 504 N.Brice St.

15- JUN 26 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 24 (Day) 1922 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said see (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowned

Fell from baby carriage into fort tuk Creek (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

..... (Duration) ....yrs. ....mos. ....ds.

(Signed) J. C. Hennessy M. D. (Coroner.)

June 25 1923 (Address) 2 B. Eden Avenue City.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill Cmetery. DATE OF BURIAL, June 26 1923

20-UNDERTAKER, John F. Denny. ADDRESS 715 Light St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

87026/64 6th

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 77026

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Stevens

(a) RESIDENCE NO. Bengies ST. WARD Bengies, Md.

(Usual place of abode)

Length of residence in city or town where death occurred ~~yrs.~~ ~~mos.~~ 4 days How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give City or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 22, 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John H. Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUN 26 1923, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1923

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1923, to June 25, 1923.

that I last saw him alive on June 25, 1923.

and that death occurred, on the date stated above, at 12.30 A. m.

The CAUSE OF DEATH* was as follows:

Measles (duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) A. R. Mirick M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Zion Lutheran Cemetery	June 26 23
20 UNDERTAKER	ADDRESS
Fredk Lauer & Son	Fullerton

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77027

CERTIFICATE OF DEATH

57 D77027

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 Colburton ST., 16 WARD)

2-FULL NAME Mrs Annie Eliza Landing

(a) RESIDENCE NO. 609 Colburton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert T Landing

6 DATE OF BIRTH (month, day, and year) Oct 22 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	69	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) Dorchester Co (State or country) Md

PARENTS

10 NAME OF FATHER Henry Condon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Not K.

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Benjamin T Landing

(Address) 609 Ashburton St

15 JUN 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1923, to June 24, 1923, that I last saw her alive on June 24, 1923, and that death occurred, on the date stated above, at 3.55 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

Diabetis Mellitis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Coma (Uremic)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Chemical & Microscopic

(Signed) C. K. Killeen M. D.

6-25, 1923 (Address) 1120 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL June 26 23

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77028

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D77028

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1721 N. Collington Ave ST., 8 WARD)

2-FULL NAME Helen Biddison

(a) RESIDENCE NO. 1721 N. Collington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Jay Biddison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Nicoll

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Jay Biddison (Address) 1721 N. Collington Ave

15 JUN 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1923

17

I HEREBY CERTIFY, That I attended deceased from June 25, 1923, to June 25 1923

that I last saw h alive on June 25, 1923

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Due to Maternal Heart Prostration and Ante-Partum Hemorrhage (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Partial Placenta Previa (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jos L. Volkmann M.D.

(Address) 14 So Broadway

June 26, 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem — DATE OF BURIAL June 26 1923

20 UNDERTAKER H. Sandra Sons — ADDRESS 1710 Pearl St

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77029

CERTIFICATE OF DEATH.

182 D77029

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. Pier 6 Canton St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME. John L. Coffey

(Residence in Baltimore: No. none St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Unknown, (Month) (Day) (Year)

7-AGE. About 41 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Seaman
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). N C.

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

15-

Filed JUN 26 1923, 19.. ROBERT R. KRAMER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 24th, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ...

(Duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.
(Coroner)

June 26 1923 (Address) Curtis Bay

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mount Carmel Cem. DATE OF BURIAL, June 26 1923

20-UNDERTAKER H. Sander Sons ADDRESS 1710 Pratt St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77030

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D77030

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 1624 E. Oliver St

CITY OF BALTIMORE: (No. 1624 E. Oliver ST., 8 WARD)

2-FULL NAME Sarah R. Dietz

(a) RESIDENCE NO. 1624 E Oliver ST., 8 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 86 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Dietz

6 DATE OF BIRTH (month, day, and year): Nov 15 1836

7 AGE — Years: 86 — Months: 7 — Days: 9 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Jacob Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Holland

12 MAIDEN NAME OF MOTHER: Mary Ann Bliss

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Sarah E. Dietz

(Address): 1624 E Oliver St

15 Filed JUN 26 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1923

17

I HEREBY CERTIFY, That I attended deceased from June 15 1923 to June 24 1923

that I last saw her alive on June 24 1923,

and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Cerebro Sclerosis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. C. Macdonald M. D.

June 25 1923 (Address) 1546 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: June 26 1923

20 UNDERTAKER: H. Sander Sons — ADDRESS: 1710 Reed St

TO

DATA / AN EF LY SC AND HEAL NEST THAN

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RE mation should be carefully supplied. AGE sh CAUSE OF DEATH in plain terms, so that it m TION is very important. See instructions on b

S. ...—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77031

CERTIFICATE OF DEATH.

129 D77031

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 N Fulton Avenue ST. 15 WARD) 45

2-FULL NAME Harry Lee Cannoles

(a) RESIDENCE NO. 1316 N Fulton Avenue ST. 15 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 8 mos. 14 ds. How long in U. S., if of foreign birth? 51 yrs. 8 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Blanch Harris Cannoles

6 DATE OF BIRTH (month, day, and year) Oct-11-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	8	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Instructor of
(b) General nature of industry, business, or establishment in which employed (or employer): Music
(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER John W. Cannoles

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER Christine Weigel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant Mrs Blanch Harris Cannoles
(Address) 1316 N Fulton Avenue

15 JUN 26 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25th 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 16th, 1923, to June 25th, 1923, that I last saw him alive on June 24th, 1923, and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Generals arterio-sclerosis

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis - chronic

(duration) one yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diagnosis

(Signed) T. W. Keown. M. D.

June 25 1923 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: June-28-23

20 UNDERTAKER: STEWART & MOWER COMPANY — ADDRESS: [illegible] NORTH AVE

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See Instructions on back of certificates.

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Spec.—1-10-21—M&T—1500 Bks.

K

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77032

CERTIFICATE OF DEATH.

194 D77032

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1714 Bolton ST., 14 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Elizabeth Meredith

(a) RESIDENCE NO. 1714 Bolton ST., 14 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. 4 mos. 17 ds. How long in U. S., if of foreign birth? 83 yrs. 4 mos. 17 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
~~Female~~ Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 8, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	4	17	

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John F Meredith

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Miss M.M. Smith (neice)
(Address) 1329 Park Avenue

15 Filed JUN 26 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1923

17 I HEREBY CERTIFY, That I attended deceased from July . 1921 . to June 25 . 1923 .
that I last saw h~~e~~ alive on June 25 . 1923 .
and that death occurred, on the date stated above, at 2 30 A. m.
The CAUSE OF DEATH* was as follows:

Heat prostration and
Old age -

(duration) ... yrs. — mos. — ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None -

(Signed) John D. Kelly, M. D.
, 19 (Address) 1425 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery — DATE OF BURIAL June-27-23

20 UNDERTAKER STEWART & [illegible] COMPANY (William F. [illegible], Proprietor) — ADDRESS [illegible] W. [illegible] AVE.

D77033

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77033

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH: Foot Clinton St

CITY OF BALTIMORE (No. ..... St.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME: Robt Hunter

(Residence in Baltimore: No. 415 Hanover St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: Unknown, 1 (Month) (Day) (Year)

7-AGE: about 32 yrs. — mns. ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seaman
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Unknown

PARENTS.

10-NAME OF FATHER, "

11-BIRTHPLACE OF FATHER (State or Country), "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept Eastern Dist

(Address)

JUN 26 1923 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 24, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, Autopsy or inquiry) thereon and from the evidence obtained at said (Inquest, Autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos.

(Signed) Thos. B. Foot M. D.

(Coroner)

June 26 1923 (Address) Curtis Bay Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, | DATE OF BURIAL, ..., 19....

20-UNDERTAKER | ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

0382

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77034

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77034

41

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2403 Eager Place ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian B. Hladik

(a) RESIDENCE NO. 2403 Eager Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Edward Hladik

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Barbara Havlik

13 BIRTHPLACE OF MOTHER (city or town) Bohemia (State or country)

14 Informant Edw. R. Hladik

(Address) 2403 Eager Place

15 Filed JUN 28 1923, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1923

17

I HEREBY CERTIFY, That I attended deceased from June 24, 1923, to June 24, 1923

that I last saw h alive on 19

and that death occurred, on the date stated above, at 11 14 P. m

The CAUSE OF DEATH* was as follows:

Cellulitis of left upper leg

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 18, 1923

Was there an autopsy? No

What test confirmed diagnosis? Laboratory findings

(Signed) Vincent Goodall, M. D.

, 19 (Address) 845 W Baltimore St City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill Cem	Jun 27 1923
20 UNDERTAKER	ADDRESS
Geo M. Frush & Son	811 N Wolfe

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77035

CERTIFICATE OF DEATH.

90 D77035

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. Gen Hospital (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Goldsborough

(a) RESIDENCE NO. 18 W Hamilton St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male | 4 COLOR OR RACE white | 5 Single, Married, Widowed, or Divorced, (write the word) widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Buchanan Goldsborough

6 DATE OF BIRTH (month, day, and year) April 18 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Civil Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co Md

PARENTS

10 NAME OF FATHER William Goldsborough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbot Co Md

12 MAIDEN NAME OF MOTHER Goldsborough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co Md

14 Informant Dr Robert S Henry

(Address) Balt Md

15 JUN 26 1923 ROBERT R. KRAUTH Registrar of Vital Statistics

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1923

17

I HEREBY CERTIFY, That I attended deceased from June 15 1923 to June 25 1923

that I last saw him alive on June 25 1923

and that death occurred, on the date stated above, at 5:05 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Myocarditis

(duration) not known

CONTRIBUTORY (Secondary) Cardiac failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. H. Wilkerson M. D.

, 19 (Address) Maryland General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Easton Maryland	June 26 1923
UNDERTAKER Henry H Jenkins Son & Co	ADDRESS Eutaw & Lexington Sts

Spec.—1-10-21—M&T—1500 Bks.

D77036

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D77036

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1906 Orleans ST. 6 WARD)

2-FULL NAME Christopher E. Winterling

(a) RESIDENCE NO. 1906 Orleans ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 60 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced (a) HUSBAND of (b) WIFE of Late Margaret Winterling

6 DATE OF BIRTH (month, day, and year) May 11 52

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Harness Maker

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Balto Harness Co

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas. E. Winterling

(Address) 1906 Orleans

15 JUN 26 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1923

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1923, to June 24, 1923, that I last saw him alive on June 24, 1923, and that death occurred, on the date stated above, at 12 50 A m.

The CAUSE OF DEATH* was as follows:

Acute Dilation Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm. A. Brodrick M. D.

June 24 1923 (Address) 66 Dolphin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem. DATE OF BURIAL June 26 1923

20 UNDERTAKER Philip Hennig ADDRESS 2016 Orleans

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D77037

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 D77037

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 152 Wilson St. 14 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Margaret Louisa Sanders

(Residence in Baltimore: No. 152 Wilson St.: 67 yrs. 7 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: October 29, 1855 (Month) (Day) (Year)

7 AGE: 67 yrs. 7 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House-work
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9 BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: George W. Sumwalt

11 BIRTHPLACE OF FATHER (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Margaret Hearsch

13 BIRTHPLACE OF MOTHER (State or country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Grace S. Sanders

(Address) 152 Wilson St.

15 JUN 26 1923

Filed , 19 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June 25, 1923 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from , 1923, to June 25 1923 that I saw h[illegible] alive on June 25 , 1923 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma
Nasal Infection

(Duration) 2 yrs. [illegible] mos. [illegible] ds.

Contributory (SECONDARY) [illegible]

(Duration) [illegible] yrs. [illegible] mos. [illegible] ds.

(Signed) [illegible]

6/26 1923 (Address) 900 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death: yrs. mos. ds. In the State: yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park — DATE OF BURIAL: June 27 1923

20 UNDERTAKER: John F. Denny — ADDRESS: 715 Lig[illegible]

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77038

CERTIFICATE OF DEATH.

74-001 D77038

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1304 Marshall St. ST., 23 WARD)

2-FULL NAME Anna Magdalena. Peusch.

(a) RESIDENCE NO. 1304 Marshall ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Widowed

5a If married, widowed, or divorced (or) HUSBAND of (or) WIFE of Widow of Charles W.L. Peusch.

6 DATE OF BIRTH (month, day, and year) November 16, 1846.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	76	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER ---- Siek.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER ---- ----.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Ben A. Peusch. (son).

(Address) 4402 Springdale Ave.

15 JUN 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1923, to June 24, 1923.

that I last saw h.ed alive on June 24, 1923.

and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ---

Did an operation precede death? No. Date of ---

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Signed) Geo M Reinhardt, M. D.

6-25, 1923 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 6/26/23

20 UNDERTAKER J. J. Fahey Sons

ADDRESS 1315 Light St.

Emma O'Neil

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77039 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77039

CERTIFICATE OF DEATH. X 74-001

1-PLACE OF DEATH Volunteers of America Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 418 W. Lexington ST.: 11 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma O'Neil

(a) RESIDENCE. NO. 46 Shipway Dundalk ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Mr. M. J. O'Neil

6 DATE OF BIRTH (month, day, and year) Nov. 21, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	7	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph Kirkwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dublin

12 MAIDEN NAME OF MOTHER Emma Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dublin

14 Informant R. O'Neil
(Address) 1209 N Broadway

15 JUN 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24* 1923

17 I HEREBY CERTIFY, That I attended deceased from June 6th, 1923, to June 24, 1923
that I last saw h[illegible] alive on June 6th, 1923
and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:
Apoplexy (cerebral hemorrhage)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Generalized Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Inspection,

(Signed) Geo. G. Wells, M. D.

. 19 (Address) 1521 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	6/26/1923
20 UNDERTAKER	ADDRESS
C. J. Fanning & Son	1938 E. Lafayette

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77040

HEALTH DEPARTMENT—CITY OF BALTIMORE

90—D77040

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 825 Willow ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jerome M Revelle

(a) RESIDENCE NO. 825 Willow St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edmund R. Revelle

6 DATE OF BIRTH (month, day, and year): Nov 21 - 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: George Borevich

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Louise Borevich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Catherine M Pinto

(Address) 510 W. Franklin St.

15 Filed JUN 26 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 7, 1921, to June 25, 1923, that I last saw her alive on June 24, 1923, and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

Aortic Insufficiency (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) 6 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John Patrick M. D.

June 26 1923 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	June 27 1923

20 UNDERTAKER: Wm J. Hartwell ADDRESS 2236 E. Baltimore St.

Spec– 12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77041

CERTIFICATE OF DEATH.

D77041

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Williams

(a) Residence No. 708 Ensor St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Norman Williams

6-DATE OF BIRTH (month, day and year) October, 1893

7-AGE. 30 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Eastern Shore Md

PARENTS.

10-NAME OF FATHER, August Cardella

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Md

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Unknown

14- (Informant) Municipal Hospital Records

(Address)

15-

JUN 26 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 22 1923

17- I HEREBY CERTIFY, That I attended deceased from June 8 1923 to June 22 1923 that I last saw her alive on June 22 1923 and that death occurred, on the date stated above, at 2:15 p. m.

The CAUSE OF DEATH* was as follows:

Brain tumor (Cerebello-Pontine angle)

(Duration) 7 yrs. mos.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Immediate) (Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) N. Goldsmith M. D.

6-22 1923 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount DATE OF BURIAL, 6/26 1923

20-UNDERTAKER Edward Dudley ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Quinn

D77042 HEALTH DEPARTMENT—CITY OF BALTIMORE D77042

CERTIFICATE OF DEATH.

74-09

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8233 S. Ellwood ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Quinn

(a) RESIDENCE NO. 8233 Ellwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Quinn

6 DATE OF BIRTH (month, day, and year) Sept. 1838

7 AGE Years 84 Months Day If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship-Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Philip Quinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Gantbrun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Chas Quinn (Address) 823 S. Ellwood ave

15 Filed JUN 26 1923 ROBERT R. [illegible] Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 1922 to June 23 1923.

that I last saw him alive on June 23 1923,

and that death occurred, on the date stated above, at 7.30 a. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. McAvoy M. D.

6/24/1923 (Address) 829 S. Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL 6/27 1923

UNDERTAKER E. T. Moran

ADDRESS 300 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage

Spec.—1-10-21—M&T—1500 Bks.

D77043

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77043

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 135 S. Linwood Ave) (Ward) 1

2-FULL NAME Rose A. McClean

(a) RESIDENCE No. 135 S. Linwood ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles McClean

6 DATE OF BIRTH (month, day, and year): Dec 21 - 1858

7 AGE — Years: 64 — Months: 6 — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Patt. Jos Costello

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ire.

12 MAIDEN NAME OF MOTHER: O'Hara

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. B. Costello

(Address): 135 S. Linwood ave

15 Filed JUN 26 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1923

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1923, to June 24, 1923,

that I last saw him alive on June 24, 1923,

and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteio-Sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. J. McAvoy, M. D.

6/24/1923 (Address) 859 O. Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lathedralen — DATE OF BURIAL: 6/27 1923

20 UNDERTAKER: J. A. Moran — ADDRESS: 300 E. Baltimore

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77044

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D77044

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard Grudzynski

(Residence in Baltimore: No. 922 E. Pratt St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	single

6-DATE OF BIRTH. Sept. 25/1918. (Month) (Day) (Year)

7-AGE. 4 yrs. 8 mos. 30 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. John Grunzynski

11-BIRTHPLACE OF FATHER, (State or Country). Poland

12-MAIDEN NAME OF MOTHER. Leonore Wojciechowski

13-BIRTHPLACE OF MOTHER, (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Grunzynski

(Address) 922 E. Pratt St.

15- Filed JUN 26 1923 192 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 24/23 (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental-scalded by hot water over both lower extremities & groins & lower abdomen.

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Fallon M. D. (Coroner)

6/25/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer DATE OF BURIAL. June 26 1923

20-UNDERTAKER, John A. Weber ADDRESS 1803 Bank St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH INK AND DO NOT USE LEAD PENCIL

Spec.—1-10-21—M&T—1500 Bks.

Louisa Nowak

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77045

CERTIFICATE OF DEATH.

112 D77045

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2703 Fait ave ST., 1 WARD)

2-FULL NAME Louisa Nowak

(a) RESIDENCE NO. 2703 Fait ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Nowak

6 DATE OF BIRTH (month, day, and year) March 10 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	52	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Geo Pasela

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Antonina Regut

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant August Nowak

(Address) 2703 Fait ave

15 Filed JUN 26 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1923

17 I HEREBY CERTIFY, That I attended deceased from June 24 1923, to June 24 1923

that I last saw h[illegible] alive on June 24 1923,

and that death occurred, on the date stated above, at 830 P m.

The CAUSE OF DEATH was as follows:

Ac Gastritis

5 Hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion 1 Day

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Examined by Dr Clinton Blade

(Signed) Dr Clinton Blade M. D.

(Address) 1730 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL June 28 1923

20 UNDERTAKER John Mallahey — ADDRESS 1803 Bank

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77046

CERTIFICATE OF DEATH. X 129 D77046

1-PLACE OF DEATH Church Home and Inf. REGISTERED NO.

CITY OF BALTIMORE: (No. 176 N. Broadway ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sallie Haines

(a) RESIDENCE NO. Ellicott City. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE Years 57 Months 1 Days [illegible] If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank J Kerkwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Mayfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Elizabeth Kerkwood

(Address) Ellicott City Md

15 JUN 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1923

17

I HEREBY CERTIFY, That I attended deceased from June 25 , 1923 , to June 26, 1923 ,

that I last saw her alive on June 26, 1923

and that death occurred, on the date stated above, at 9 15 a m

The CAUSE OF DEATH* was as follows:

Cholecystitis.

Cholelithiasis.

(duration) - yrs. - mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 25. 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Richard S. Coblentz, M. D.

, 19 (Address) Church Home and Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Johns Cemy Ellicott City DATE OF BURIAL June 27 1923

20 UNDERTAKER Jesse M Shaver ADDRESS Ellicott City

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

D77047 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77047

CERTIFICATE OF DEATH. 74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bayr Academy Hotel St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry C. J. Chaney

(Residence in Baltimore: No. Bayr. Academy Hotel St.; yrs., 59 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: Sept (Month) ..... (Day) 1863 (Year)

7-AGE: 59 yrs. 8 mos. — ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Marine Painter
(b) General nature of industry, business, or establishment in which employed (or employer): "

9-BIRTHPLACE, (State or Country): Balto. Md

PARENTS.

10-NAME OF FATHER: Wm. C. Chaney

11-BIRTHPLACE OF FATHER, (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Ellen Reynolds

13-BIRTHPLACE OF MOTHER, (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elsworth Chaney

(Address) 2626 St Paul St

15- Filed JUN 26 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 25 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) No history.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy M. D. (Coroner.)

June 26 1923. (Address) 2802 Edmondson Av

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park DATE OF BURIAL: June 27 1923

20-UNDERTAKER: Geo. W. Weber ADDRESS 2700 Edmondson Av

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77048

CERTIFICATE OF DEATH.

X 185 D77048

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eliza Matthews

(a) RESIDENCE NO. 1303 Pennsylvania ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Don't Know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

070

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER John Matthews

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Caroline Jones

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Jas. H. Bruce
(Address) 1303 Pennsylvania

15 JUN 26 1923 ROBERT R. KRAMER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Pneumonia & Pulmonary Edema

Due to Fatty Degeneration of Heart

(Signed) H. R. Grumpelt M. D.
(Coroner.)

6-26 1923 (Address) 117 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence Annapolis Md

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dulaney Valley Md

DATE OF BURIAL 6/26 1923

20 UNDERTAKER James H. Dennis

ADDRESS 203 Gorsuch

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77049 ✓ 29 D77049

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 Pratt Mann ST., 15 WARD)

2-FULL NAME Tomlinson P Pond

(a) RESIDENCE NO. 321 Pratt Mann ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vernia Pond

6 DATE OF BIRTH (month, day, and year) Sept 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	49	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) Dr

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Nathaniel Pond

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Julia Barbee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Mrs Vernia Pond
(Address) 321 Pratt St

15 Filed ..... 19 ..... Registrar

UN 26 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1923

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1923. to June 25, 1923.
that I last saw him alive on June 25, 1923
and that death occurred, on the date stated above, at 9:50 P. m.
The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Chronic
Uraemia Coma.

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary + Physical

(Signed) William H. Mogle M. D.

June 26, 1923 (Address) 1209 Pratt Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel — DATE OF BURIAL June 28 1923

20 UNDERTAKER Thomas Joseph Whitaney — ADDRESS 1364 W Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77050

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 D77050

CERTIFICATE OF DEATH

1-PLACE OF DEATH 3734 E Lombard St

CITY OF BALTIMORE: (No.) 3734 E. Lombard ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H Seyford

(a) RESIDENCE NO. 3734 E Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. — mos. 3 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E Seyford

6 DATE OF BIRTH (month, day, and year): June 23, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	—	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): ~~Retired~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry Seyford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mary E Seyford (wife)

(Address) 3734 E Lombard

JUN 26 1923

Robert P. Harrison, M.D.
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25 1923

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1923, to June 25, 1923,

that I last saw him alive on June 25, 1923

and that death occurred, on the date stated above, at 4 a. m.

THE CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual tests

(Signed) A L Macdonald, M. D.

(Address) 1540 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Mays Chapel Cemetery, Baltimore Md

DATE OF BURIAL: June 27 1923

20 UNDERTAKER: Robt S Turner Inc

ADDRESS 1111 N Broadway

D. —WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Bks.

D77051

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

181-03 D77051

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Hurwitz

(a) Residence No. 1703 Quarrier St., Charleston W. Va. Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Benj Hurwitz

6-DATE OF BIRTH (month, day and year) July 2 1880

7-AGE. 43 yrs. 11 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country). Canada

PARENTS.

10-NAME OF FATHER, Ralph Webster

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Canada

12-MAIDEN NAME OF MOTHER, Julia ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Canada

14- (Informant) Benj Hurwitz

(Address) Charleston W Va

15- Filed 192.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 26 '23

17- I HEREBY CERTIFY, That I attended deceased from June 25 19 23 to June 26 19 23

that I last saw h.. alive on June 26 19 23

and that death occurred, on the date stated above, at 9 ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Surgical Shock

Chronic Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? Cerebral Hemorrhage

Did an operation precede death? Yes Date of 6-26 23

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) H. J. Sanabrier M.D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Charleston W Va DATE OF BURIAL. 6/26 19 23

20-UNDERTAKER. Jack Lewis ADDRESS 1405 E. Kanawha

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HN2 6 1923

D77052

HEALTH DEPARTMENT—CITY OF BALTIMORE

52 D77052

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1097 W Fayette St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Apple

(Residence in Baltimore: No. 1097 W Fayette St.) Life yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: April (Month) 7 (Day) 1911 (Year)

7-AGE: 12 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country): Salt Lk City

PARENTS:

10-NAME OF FATHER: Morris Apple

11-BIRTHPLACE OF FATHER, (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Mary Offenberg

13-BIRTHPLACE OF MOTHER, (State or Country): Scotland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Apple

(Address) 1097 W Fayette

15- JUN 26 1923

Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 25 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Dea death on the day stated above.

The CAUSE OF DEATH* was as follows:

Inflamatory Rheumatism

(Duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(Duration) 1 yrs. mos. ds.

(Signed) James M Hudson M. D. (Coroner)

June 25 1923 (Address) 100 E Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL: Beth Hebrew Cem DATE OF BURIAL. 6/26 1923

20-UNDERTAKER: Jack Levers ADDRESS 1439 E Balto

U. S.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D77053

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77053

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md General Hosp St. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Katherine Hartman

(a) RESIDENCE NO. 2 W Selby Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bernard Hartman

6 DATE OF BIRTH (month, day, and year): Nov 30 1892

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
30	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Morton McHale

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Primen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Bernard Hartman (Address) 2 W Selby Ave

15 FILED JUN 26 1923, 19

Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-25-23

17 I HEREBY CERTIFY, That I attended deceased from 6-22-23, 19 to 6-25-23, 19 that I last saw her alive on 6-25-23, 19 and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Hypostasis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary): Fracture of Nose

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6-22-23

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Signs

(Signed) Jno A Dempsey M. D.

19 (Address) 111 Gerstner Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Washington DC — DATE OF BURIAL: June 27 1923

20 UNDERTAKER: Josiah Syfer — ADDRESS: 1600 W North Ave

WARNING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77054 HEALTH DEPARTMENT—CITY OF BALTIMORE D77054

1644 9.50 P.M.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John D. Vannoy.

(a) RESIDENCE NO. Buchanan, W. Va. ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. John D. Vannoy.

6 DATE OF BIRTH (month, day, and year) Jan. 10, 1870.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	53.	5.	16.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Lenhill L. Vannoy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Mary Bush.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed JUN 26 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1923, to June 26, 1923, that I last saw him alive on June 26, 1923, and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction
following Operation
for Carcinoma of Rectum
(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 6-18-23

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) J. L. Resident, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Buchanan W. Va. DATE OF BURIAL 6-26 19

20 UNDERTAKER W. J. Tiedemann Sons Funeral Home ADDRESS

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D77055 HEALTH DEPARTMENT—CITY OF BALTIMORE D77055

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of BALTIMORE: (No. Eutaw Place Avenue St., 14 Ward) Registered No. 139

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Olivia L. Jerome

(a) Residence No. Altamont Hotel St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec 22 1852

7-AGE 71 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Duties

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER Jeremiah Kimberly

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Olivia Stansbury

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) John H. L. Jerome

(Address) Altamont Hotel

15- Filed 192 Registrar Robert P. Harrison,

Burial Permit

JUN 26 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 25. 23

17- I HEREBY CERTIFY, That I attended deceased from June 18 19 23, to June 25, 19 23, that I last saw her alive on June 25, 19 23, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Interstitial Uterine fibroid

Several Years

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Anuria & Uraemia 5 days

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys Exam

(Signed) Robert W. Mifflin M. D.

June 26 1923 (Address) 1076 Mad St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem | DATE OF BURIAL, June 27 1923

19-UNDERTAKER John J. Mitchell | ADDRESS 120 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D. 77056

HEALTH DEPARTMENT—CITY OF BALTIMORE

D. 77056

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp ST., 76 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Scoggins

(a) RESIDENCE NO. 3440 Lanvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male. (2)

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	12			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Co
(State or country) Md.

PARENTS

10 NAME OF FATHER ~~Howard~~ Frank Scoggins

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md.

12 MAIDEN NAME OF MOTHER Theresa Smith

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant Frank Scoggins.
(Address) 3440 Lanvale Ave

JUN 26 1923

Robert P. Harrison,
Registrar.
~~Burial Permit Clerk.~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1923

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1923, to June 24, 1923, that I last saw him alive on June 24, 1923, and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Acute Gastro-Enteritis

(duration) yrs. mos. 1 wk ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J. C. Manning, M. D.

(Address) 1300 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL June 27 1923

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of ck of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D77057

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77057

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 15 Ward) 106-001

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mrs. Claire Gehring

(a) Residence No. 2806 Garrison Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Gehring

6-DATE OF BIRTH (month, day and year) April 3, 1889

7-AGE. 34 yrs. 2 mos. 22 ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer). at home

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Chas. O'Brien

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ind.

12-MAIDEN NAME OF MOTHER, Margaret Multon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ind.

11- (Informant) J. William Gehring

(Address) 2806 Garrison Ave

15- Filed JUN 26 1923 192 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 25/23

17. I HEREBY CERTIFY, That I attended deceased from June 15 1923 to June 25 1923

that I last saw h. alive on June 25 1923

and that death occurred, on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:

Acute Yellow Atrophy of Liver

5 wks.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia & Edema

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. J. Bergagna M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Ch — DATE OF BURIAL, June 28 1923

20-UNDERTAKER. Lilly Ed Zeiler — ADDRESS 403 S. Wolfe St

Burial Permit Clerk.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77058

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. 422 ~~N~~ Fulton St.: 6 Ward) 57

REGISTERED No. D77058

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Fuller

(a) RESIDENCE. No. 422 N Fulton ave St. 6 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry H. Fuller

6 DATE OF BIRTH (month, day, and year) Mar 3 - 1866

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Phillips Wilkinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Kesler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Harry H. Fuller
(Address)

15 Filed JUN 26 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1923, to June 26, 1923.

That I last saw h[illegible] alive on June 26, 1923.

and that death occurred, on the date stated above, at 2.55 P m.

The CAUSE OF DEATH was as follows:

Bronchopneumonia (terminal)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus (duration) 3(?) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & laboratory

(Signed) Isidor S. Jay M. D.

. 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dale Lawn — DATE OF BURIAL 6-28 1923

20 UNDERTAKER Mrs Albert Fuller — ADDRESS 4806 Harford

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77059

D77059

CERTIFICATE OF DEATH.

185

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 Valley ST., 9 WARD)

2-FULL NAME Amelia F. Stein

(a) RESIDENCE No. 1315 Valley ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 11 mos. 6 ds. How long in U. S., if of foreign birth? Dft yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed or divorced (or) WIFE of ~~HUSBAND of~~ the late Charles Stein

6 DATE OF BIRTH (month, day, and year) July 19-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md (State or country)

PARENTS

10 NAME OF FATHER M. Deckman

11 BIRTHPLACE OF FATHER (city or town) Not Known (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known (State or country)

14 Informant Mrs Sylvain J. Ryan

(Address) 1315 Valley St

15 Robert F. Harrison, Registrar

JUN 26 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10, 19 23, to June 25, 19 23, that I last saw h[illegible] alive on June 22, 19 23, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 7 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. E. Stone, M. D.

June 26, 19 23 (Address) 501 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL June 28, 23

20 UNDERTAKER Henry Hoeck Son — ADDRESS 1301 E Eager

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77060 HEALTH DEPARTMENT—CITY OF BALTIMORE D77060

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. Franklin Square Hospital 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earnest Hopkins

(Residence in Baltimore: No. 412 Walnut St St.; yrs.... mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH. 1905
(Month) (Day) (Year)

7-AGE. 18 yrs. mos. ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cart Driver
(b) General nature of industry, business, or establishment in which employed (or employer): Contractor

9-BIRTHPLACE, (State or Country): Balto City

PARENTS

10-NAME OF FATHER, Charles Hopkins

11-BIRTHPLACE OF FATHER, (State or Country). Maryland

12-MAIDEN NAME OF MOTHER, Lucie Pearson

13-BIRTHPLACE OF MOTHER, (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Hopkins

(Address) 412 Walnut St

15- Dec. 192.. Registrar. Robert P. Harrison, Burial Permit Clerk

JUN 26 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 24 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to (his) death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage from bullet wound severing femoral artery & vein

(Duration) Hours mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) James W. Freeburn M. D. (Coroner)

June 25 1923 (Address) 100 E. Chase St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death? 1612 Bond St

Former or usual residence 412 Walnut St

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn — DATE OF BURIAL. 6-27-23

20-UNDERTAKER. Hurd Easton — ADDRESS 906 Pa Ave

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77061

CERTIFICATE OF DEATH.

74-002

D77061

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 Glenolden Ave ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Webb.

(a) RESIDENCE NO. 603 Glenolden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Otway Webb.

6 DATE OF BIRTH (month, day, and year) Dec. 21. 1823

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79.	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Thomas Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Alice Shaw.

(Address) 603 Glenolden Ave

15 Filed JUN 26 1923, 19 Robert F. Harrison. Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26. 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1923, to June 26, 1923, that I last saw her alive on June 26, 1923, and that death occurred, on the date stated above, at 10. A. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex.

(Signed) E. M. Lumpkin, M. D.

(Address) 826. N. Carrollton

June 26 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Merrypoint Va.	June 27. 1923

20 UNDERTAKER Mr. & Mrs. John W. Teufel & Son ADDRESS 841 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS shall state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—L.B.R.S.—400 Bks.

D77062

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

D77062

Registered No. 118-0

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G. Becker

(a) Residence: (No. 202 W. Monument St., Ward)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mrs Emily

6-DATE OF BIRTH (month, day and year) March 23, 1856

7-AGE, 67 yrs. 2 mos. 25 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, John Becker

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Emelie Becker

(Address) 202 W. Monument

15- Robert P. Harrison, Registrar.

JUN 26 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 23 1923

17- I HEREBY CERTIFY, That I attended deceased from June 23 1923 to June 23, 1923 that I last saw h[illegible] alive on June 23, 1923 and that death occurred, on the date stated above, at 8.05 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Toxemia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? 202 W. Monument

Did an operation precede death? Yes Date of 6/23/23

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) D. J. Thompson M. D.

6/25 1923 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL, June 27 1923

20-UNDERTAKER, Mr. & Mrs. John W. Teufel & Son — ADDRESS 801 W. Fayette

8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77063

CERTIFICATE OF DEATH.

100-001 D77063

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2517 W. Baltimore St. 20 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Benjamin Wilson Harper

(Residence in Baltimore: No. 2517 W. Baltimore St.; 7 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~SINGLE~~, MARRIED, ~~WIDOWED~~, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Nov 23, 1871
(Month) (Day) (Year)

7-AGE, 52 yrs. 7 mos. 3 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Steamfitter
(b) General nature of industry, business, or establishment in which employed (or employer): 60

9-BIRTHPLACE, (State or Country), St. Mary's Co Md.

PARENTS.

10-NAME OF FATHER, John W. Harper

11-BIRTHPLACE OF FATHER (State or Country), New York, N. Y.

12-MAIDEN NAME OF MOTHER Sallie Thompson

13-BIRTHPLACE OF MOTHER (State or Country), St. Mary's Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. B. W. Harper

(Address) 2517 W. Balto St.

15-

Filed JUN 26 1923 1923

Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 25, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 6 1923, to June 25 1923, that I saw h[illegible] alive on June 25 1923, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Emil A. Kalm M. D.

June 26 1923 (Address) 910 N. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem. DATE OF BURIAL, June 28 1923

20-UNDERTAKER Joseph B Cook ADDRESS 1003 N Balto St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D77064

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 109-001 D77064

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Alexander

(a) RESIDENCE NO. Haverford Apts Pa. ST., Atlantic City, N.J. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 12, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7 yrs	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of Industry, business, or establishment in which employed (or employer) ..... nos

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Johnstown Pa

PARENTS

10 NAME OF FATHER Samuel Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 JUN 27 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1923.

17

I HEREBY CERTIFY, That I attended deceased from June 25, 1923, to June 26, 1923, that I last saw h Cralive on June 26, 1923, and that death occurred, on the date stated above, at 10.55 p.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage. Post Operative

day of operation

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Operation – Tonsilectomy & Adenoidectomy

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of June 26-23

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) L. M. Higgins, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

17 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa — Johnstown Pa

DATE OF BURIAL June 27 1923

20 UNDERTAKER H E Hughes

ADDRESS 1st & Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Home, 1301 Pal-Park Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77065

CERTIFICATE OF DEATH.

49 D77065

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1500 Madeira ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Willing

(a) RESIDENCE NO. 1500 Madeira ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A Franklin

6 DATE OF BIRTH (month, day, and year) Feb 23 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Albert Willing

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Whalen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mary A Willing (Address) 1500 Madeira

15 Filed JUN 27 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1923

17 I HEREBY CERTIFY, That I attended deceased from May 19 23 to June 25 19 23

that I last saw h alive on June 25, 19 23

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma Prostate

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) J. E. Kraber M. D.

June 26 1923 (Address) 1301 N Pat Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL June 25 1923

20 UNDERTAKER Wm Cook & Son ADDRESS

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77066

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 ✓ D77066

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST.: 28 WARD)

2-FULL NAME Elizabeth A. Quinn

(a) RESIDENCE. No. Mt Hope Retreat ST., 28 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
~~Male~~ Female	White	Widowed

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of Mr Quinn

6 DATE OF BIRTH (month, day, and year) Dec 15 - 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
abt	58	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New York City
(State or country)

PARENTS

10 NAME OF FATHER John McShane

11 BIRTHPLACE OF FATHER (city or town) (?)
(State or country) New York

12 MAIDEN NAME OF MOTHER Eliz. A. Eccles

13 BIRTHPLACE OF MOTHER (city or town) (?)
(State or country) England

14 Informant Registry Mt Hope Retreat
(Address) Mt Hope Md

15 Filed ..., 19... ROBERT P. KRANTZ, Registrar.
JUN 27 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 19

17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1922, to June 26, 1923, that I last saw h... alive on June 26, 1923, and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Epilepsy (Chronic)

abt (duration) 30 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Epileptic Hydrocephalus.

abt (duration) 5 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flannery, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 6/28 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

164233 D77067

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77067

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Waters

(a) RESIDENCE NO. 906 Druid Hill Ave ST., City WARD

(Usual place of abode)

Length of residence in city or town where death occurred ~~Unknown~~ mos. ~~Us~~ How long in U. S., if of foreign birth? yrs mos ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook 07

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: ~~Unknown~~

11 BIRTHPLACE OF FATHER (city or town) (State or country): ~~Unknown~~

12 MAIDEN NAME OF MOTHER: ~~Unknown~~

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ~~Unknown~~

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 JUN 27 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1923

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1923, to June 22, 1923, that I last saw h[illegible] alive on June 22, 1923, and that death occurred, on the date stated above, at 10:45 P, m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) E Bowles Andrus, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Princess Anne Md.

DATE OF BURIAL: 6-26 1923

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

163916. D77068

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 D77068

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL, 13 ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 13 WARD)

2-FULL NAME John Dorsey

(a) RESIDENCE NO. Mt. Royal Reservoir House WARD City
(Usual place of abode)

Length of residence in city or town where death occurred Unknown How long in U. S., if of foreign birth? yrs. mos. da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary S. Dorsey

6 DATE OF BIRTH (month, day, and year) May 12, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	36	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Trainman

(b) General nature of industry, business, or establishment in which employed (or employer) B&O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James W. Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUN 27 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1923

17

I HEREBY CERTIFY, That I attended deceased from May 24. 1923. to June 25. 1923.

that I last saw h alive on June 25. 1923.

and that death occurred, on the date stated above, at 7.05 A. m.

The CAUSE OF DEATH* was as follows:

Brain tumor - cholesteatoma above 3rd ventricle

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Intracranial pressure

(duration) 3 yrs. 6 mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of June 1 and June 22

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) H. U. Cushing, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: June 28 1923

20 UNDERTAKER: George F. Ruth — ADDRESS: 1735 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77069

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77069

46

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Seton Balto Gyn Hosp

CITY OF BALTIMORE: (No 1931 E. Monument ST., 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth Iluisio

(a) RESIDENCE NO. 1931 E. Monument ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Italian White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene Iluisio

6 DATE OF BIRTH (month, day, and year) 5/12/1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 837

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Italy (State or country)

PARENTS

10 NAME OF FATHER John Cardinale

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Domenica Degaro

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant Eugene Iluisio 1931 E. Monument St (Address)

15 Filed JUN 27 1923 ROBERT R. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1923

17

I HEREBY CERTIFY, That I attended deceased from June 18 (2 P.M.) 1923, to June 26 (4 A.M.) 1923, that I last saw h alive on June 26 (4 A.M.), 1923, and that death occurred, on the date stated above, at 4 A.M. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation Bronchopneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Heart Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John J. O'Connor, M. D.

, 19 (Address) Seton Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery. DATE OF BURIAL June 28 1923

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Hysterectomy
Cancer of Cervix

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77070 D77070

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1700 Carter ST.: 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Courtney Ellis

(a) RESIDENCE. NO. 1700 Carter ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Ellis

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Thomas Ellis
(Address) 3201 Barclay St

15 JUN 27 1923 ROBERT R. KRAUTER, Registrar,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1923

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1923, to June 23, 1923

that I last saw h alive on June 23, 1923

and that death occurred, on the date stated above, at 2 A, m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease
Indefinite
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Official Exam

(Signed) P. Paul Schmidt, M. D.

(Address) 1534 E. H. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 27 1923
20 UNDERTAKER	ADDRESS
Mrs. R. A. Elliott	1726 Ashland Ave

Spec.—12-20-21—E.B.R.S.—400 Bks.

Lehuhoff.

D77071

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 90 D77071

1-PLACE OF DEATH Mercy Hospital

Registered No.

City of BALTIMORE: (No. Mercy Hospital St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Sebuhoff

(a) Residence No. 2015 E. Preston St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Lehuhoff

6-DATE OF BIRTH (month, day and year) about 1884

7-AGE. 37 yrs. 2 mos. 22 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) Auto

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS

10-NAME OF FATHER, William Lehuhoff

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Elizabeth Hartz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Washington D.C.

14- (Informant) Wm Lehuhoff

(Address) 2015 E. Preston St.

15-

Filed JUN 27 1923 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 27 '23

17- I HEREBY CERTIFY, That I attended deceased from June 23 1923 to June 27 1923

that I last saw h[illegible] alive on 6-26 1923

and that death occurred, on the date stated above, at 1.20 P.M.

The CAUSE OF DEATH* was as follows:

Acute Chronic Cardiac Decompensation

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. 21 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sym & Sign

(Signed) A. J. Scroggs M.D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park DATE OF BURIAL. June 29 1923

20-UNDERTAKER. Wm Cook ADDRESS 502 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77072

CERTIFICATE OF DEATH

D77072

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas E. Phipps

(a) RESIDENCE NO. ..... ST., ... WARD Dead at A A Co

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 9 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Phipps

6 DATE OF BIRTH (month, day, and year): Oct 13. 58.

7 AGE: Years 67 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waterman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Nicholas Phipps

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Lavinia Kustner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: University Hospital records (Address)

15 FILED JUN 27 1923 ROBERT R. KRAUTER, Registrar. Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26 1923

17 I HEREBY CERTIFY, That I attended deceased from 6/[illegible]/23, 1923, to 6/26, 1923, that I last saw him alive on 6/26, 1923, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Benign hypertrophy of prostate

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Uremia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical findings

(Signed) Iron Nordent, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dale A A Co. Md. — DATE OF BURIAL: June 29 1923

20 UNDERTAKER: H M Rourke — ADDRESS: 230 N Greene

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77073

CERTIFICATE OF DEATH.

31

D77073

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST., 116 WARD)

2-FULL NAME Julia Meakins

(a) RESIDENCE No. Not known ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not stated

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Warner Stanton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Ellen White

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Hospital Records

(Address): M.T.H.

15 Filed JUN 27 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26, 1923

17

I HEREBY CERTIFY, That I attended deceased from April 7, 1923, to June 26, 1923, that I last saw her alive on June 26, 1923, and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous broncho-pneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) Harry D McCarty, M. D.

6-27-23 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arbury — DATE OF BURIAL: June 27 1923

20 UNDERTAKER: John A Henderson — ADDRESS 1502 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77074

CERTIFICATE OF DEATH.

10 D77074

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 Arlington Ave ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin J. Quinlan

(a) RESIDENCE. NO. 920 Arlington Ave ST. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 21 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W.

5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hartford Co
(State or country) Md

PARENTS

10 NAME OF FATHER Philip Quinlan

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Antoun

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Mary L Corbett
(Address) 920 Arlington Ave

15 Filed JUN 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26th 1923

17

I HEREBY CERTIFY, That I attended deceased from June 23, 1923, to June 26, 1923,
that I last saw her alive on June 25, 1923,
and that death occurred, on the date stated above, at 5 P m.
The CAUSE OF DEATH* was as follows:

Organic heart disease
(Mitral Stenosis & regurg)
(duration) 15 yrs. — mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual physical signs

(Signed) H. M. Slaughter M.D.

6/27 1923 (Address) 2733 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Leadenhall Cem Md	June 28-1923

20 UNDERTAKER Belsinger Bros ADDRESS W. 23rd St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MSA • S • A

Spec.—1-10-21—M&T—1500 Bks.

D77075 HEALTH DEPARTMENT—CITY OF BALTIMORE 9 D77075

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 Belt St. ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence W. Miller

(a) RESIDENCE NO. 1811 Belt St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	[redacted]

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 7 1923

7 AGE Years	Months	Days	If LESS than 1 day,... hrs or ... min.
	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Lawrence Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Louisanna

12 MAIDEN NAME OF MOTHER Marie M. Pirrash

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs. Miller (Address) 1811 Belt St.

15 Filed JUN 27 1923 ROBERT R. KRAUTER Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1923, to June 26, 1923, that I last saw h... alive on June 26, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Surgical

(Signed) J. Hartman M. D.

1923 (Address) 1811 Randall St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem

DATE OF BURIAL 6/27 1923

20 UNDERTAKER L. F. McCully

ADDRESS 1130 E. Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

KODAK

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77076

CERTIFICATE OF DEATH.

90 D77076

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 702 E. 20th ST.: 9 WARD)

2-FULL NAME Mrs. Frances H O'Neill

(a) RESIDENCE. No. 702 E. 20th ST., 9 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: John O'Neill

6 DATE OF BIRTH (month, day, and year): April 4th 1861

7 AGE: Years 62 Months 2 Days 22 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Patrick Hanley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Thomas F. O'Neill
(Address): 702 E. 20th St. City

15 Filed ..... 19.....

Robert P. Harrison, Registrar

JUN 27 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26 1923

17 I HEREBY CERTIFY, That I attended deceased from February 3, 1923, to June 26, 1923

that I last saw him alive on June 26, 1923

and that death occurred, on the date stated above, at 9.40 A m.

The CAUSE OF DEATH* was as follows:

Coronar Heart Disease

(duration) 2 yrs. 5 mos. 26 ds.

CONTRIBUTORY (Secondary): Nephritis

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Reginald J Tovey, M. D.

6-26 1923 (Address) 414 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: June 27th 19 23

20 UNDERTAKER: Ed. Weidefeld

ADDRESS: 1524 E 22 St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77077

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77077

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Newton Nichols

(Residence in Baltimore: No. 1107 N. Front St. St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	?

6-DATE OF BIRTH.

.....1.....
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
47 yrs. mos. ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Fisher
(b) General nature of Industry, business, or establishment in which employed (or employer). ?

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- JUN 27 1923 Robert P. Harrison, 192..... Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 19, 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Junc Colo Cas

(Duration) yrs. mos. ds.

(Signed) W. J. Ruley M. D.
(Coroner.)

June 26, 1923. (Address) 16 E. Fayette

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death 1 dy yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. PUBLIC CEMETERY. DATE OF BURIAL. JUN 27 1923

20-UNDERTAKER. Geo. Pearce & Son, Undertaker. ADDRESS JUN 27 1923

NOTE—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

D77078

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77078

CERTIFICATE OF DEATH.

1 PLACE OF DEATH — City of Baltimore (No. Bay View St. 22 Ward) — Registered No. C 199

2 FULL NAME — James Greeberger

(Residence in Baltimore: No. 708 Pepper St. St.; yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: Unknown, ... (Month) ..... (Day) ..... (Year)

7-AGE: about 71 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.f

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Unknown

PARENTS.

10-NAME OF FATHER: 11

11-BIRTHPLACE OF FATHER (State or Country): 11

12-MAIDEN NAME OF MOTHER: 11

13-BIRTHPLACE OF MOTHER (State or Country): 11

14-THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Asst Supt Eastern Dist

(Address)

15-

Filed ....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Clerk.

JUN 27 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: June 24, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained thereby (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage Brain
Fractured Skull
Supposed to have been struck with object in hands of unknown person

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. B. Horton M. D.

June 27 23 (Address) Curtis Bay Balto, Md

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENCE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: PUBLIC CEMETERY.

DATE OF BURIAL, ..., 19...

20-UNDERTAKER: Commissioner Health,

ADDRESS JUN 27 19

Per. Wm. E. WOODALL

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Blks.

D77079

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77079

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 237 S. Highland Ave. WARD 16)

2-FULL NAME Madeline E. Haalbeck.

(a) RESIDENCE NO. 237 S. Highland Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Haalbeck.

6 DATE OF BIRTH (month, day, and year) Aug. 22 - 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer -

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Adam Roth.

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Pauline Liberty.

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Frank Haalbeck (Address) 237 S. Highland Ave

15 Filed JUN 27 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 3, 1923, to June 25, 1923, that I last saw h[illegible] alive on June 25, 1923 and that death occurred, on the date stated above, at 8.50 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Laryngeal tbc.

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? -

(Signed) Lymon S. Abbott, M. D.

, 19 (Address) 1832 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL June 28 1923

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Mo[illegible]

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77080

CERTIFICATE OF DEATH.

113 D77080

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 53 Weathersfield Ave ST., WARD)

2-FULL NAME Marion Sophia Boyd

(a) RESIDENCE NO. 573 Weathersfield Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 ~~Single~~, ~~Married~~, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 4. 1922

7 AGE Years | Months 10 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Hilsdale (State or country) Balto, Md

PARENTS

10 NAME OF FATHER William H. Boyd

11 BIRTHPLACE OF FATHER (city or town) Hilsdale (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Esther E. Renew

13 BIRTHPLACE OF MOTHER (city or town) Gettysburg (State or country) Pa.

14 Informant Mr. William H. Boyd (Address) 573 Weathersfield Rd. Balto Md

15 [illegible], 19 Registrar

JUN 27 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1923

17 I HEREBY CERTIFY, That I attended deceased from June 21 1923 to June 26 1923, that I last saw her alive on June 26 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis about 5

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Ileo Colitis about 5

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical

(Signed) Walter Sublett M. D.

, 19 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery | DATE OF BURIAL Jun 28 1923

20 UNDERTAKER Jos JOERDENS & SON | ADDRESS 27 S. Paca

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77081

D77081

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 132 Annapolis Ave WARD) 25

2-FULL NAME Samuel Dashaway

(a) RESIDENCE NO. 1321 Annapolis Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 6 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Dashaway

6 DATE OF BIRTH (month, day, and year) Dec 5, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Makers

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Saml Dashaway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Kraft

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mrs Alfred Eckles 321 Annapolis Ave

15 Filed JUN 27 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1923

17 I HEREBY CERTIFY, That I attended deceased from June 2 1923 to June 25 1923, that I last saw h[illegible] alive on June 24 1923, and that death occurred, on the date stated above, at 11.00 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Uremia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. Lewis Fiefler M. D.

June 26, 1923 (Address) 232 W Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem DATE OF BURIAL June 28 1923

20 UNDERTAKER Wm Tuckner ADDRESS Monument & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77082

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77082

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Jacoby

(a) RESIDENCE No. 4308 Kathaland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Fred Halliman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Martha Hagan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Municipal Hospital Records.

(Address)

15 Filed ..... 19 .....

Registrar

JUN 27 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 19 23

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1923, to June 26, 1923, that I last saw her alive on June 26, 1923 and that death occurred, on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Diabetic Malleleus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Gangrene of left foot (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of 6/26/23

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) A. M. Shipley, M. D.

6-27-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL June 28 1923

20 UNDERTAKER Wm J Tickner & Sons ADDRESS North Ave

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77083

CERTIFICATE OF DEATH.

D77083

179

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Old Pimlico Roads (now Hill Top Rd.) St., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Roche

(a) RESIDENCE No. Old Pimlico Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower.

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of): Bridget Roche

6 DATE OF BIRTH (month, day, and year): January 1853

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
90	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Wexford Ireland

PARENTS

10 NAME OF FATHER: John Roche

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wexford Ireland

12 MAIDEN NAME OF MOTHER: Catherine Higgins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wexford Ireland.

14 Informant (Address): John Roche Old Pimlico Rd

15 JUN 27 1923 . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 27 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10th 1923 to June 26 1923 that I last saw h living on June 26 1923 and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Uraemia.

(duration) 2 days. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Chemical test

(Signed) Robt. J. Gaudwell, M. D.

. 19 (Address) Sta. E. City.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Cem. Govane

DATE OF BURIAL: 6/29 1923

UNDERTAKER: Chas H. Evans & Son

ADDRESS: 1130 W. Fayette

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chronic

Spec.—1-10-21—M&T—1500 Bks.

77084

16H479 10 45 A.M. D77084

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 84 D77084

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Robert Laskill.

(a) RESIDENCE No. Montana Mines, W. Va. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 24, 1906

7 AGE — Years: 17. Months: 2 Days: 2. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: school.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): W. Va.

PARENTS

10 NAME OF FATHER: Ernest Laskill.

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Mollie Satterfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va.

14 Informant (Address): JOHNS HOPKINS HOSPITAL.

15 Filed JUN 28 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1923.

I HEREBY CERTIFY, That I attended deceased from June 17. 1923. to June 26. 1923.

that I last saw him alive on June 26 1923.

and that death occurred, on the date stated above, at 10 45 A.m.

The CAUSE OF DEATH* was as follows:

Brain tumor - hypophyseal duct tumor

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Postoperative thrombosis and bronchopneumonia

(duration) yrs mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of June 20 1923

Was there an autopsy? yes

What test confirmed diagnosis? Operation

(Signed) F. L. Leibrent, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fairmont W. Va

DATE OF BURIAL: 6/27/23 19

20 UNDERTAKER: A. E. Hughes

ADDRESS: 424 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77085 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 5/4-001 D77085

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 1364 Whitecrest St., | 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen Davis

(Residence in Baltimore: No. 1364 Whitecrest St., St.; 10 yrs.... mos.... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	colored	married

6-DATE OF BIRTH. about (Month) (Day) 1864 (Year)

7-AGE. 59 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Ford Carrier
(b) General nature of industry, business, or establishment in which employed (or employer): Building

9-BIRTHPLACE. (State or Country) N. Carolina

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie Nixon

(Address) 1364 Whitecrest St.

15- Filed JUN 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 25 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) 2 yrs. mos. ds.

(Signed) J. A. Hennessy M. D. (Coroner.)

June 26 1923 (Address) 201 Eastern Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	June 28 1923

20-UNDERTAKER.	ADDRESS
Joseph A Farrell	2314 Eastern Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77086

CERTIFICATE OF DEATH. 159-002

D77086

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 568 Baker St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Elizabeth Bailey

(Residence in Baltimore: No. 568 Baker St.; yrs., 2 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	colored	Married

6-DATE OF BIRTH. ..... June 25, 1923
(Month) (Day) (Year)

7-AGE. ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or. 2 min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Walter Bailey

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Rena Diggs

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)..... Rena Bailey

(Address)..... 568 Baker St

15- JUN 28 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... June 25, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said decessed came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cateur Pneumonia

½ hr.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Hennessy M. D.
(Coroner.)

June 26 1923 (Address) 200 N. Eutaw Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn DATE OF BURIAL. June 28 1923

20-UNDERTAKER. Joseph A Ferrell ADDRESS 2314 Division

Spec.—1-10-21—M&T—1500 Blks.

D77087 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77087

90

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 Forrest ST., 10 WARD)

2-FULL NAME Peter F. Fallon

(a) RESIDENCE NO. 1006 Forrest ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Fallon

6 DATE OF BIRTH (month, day, and year) Dec. 20 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Retired Policeman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Edw. Fallon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Lamon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Elizabeth Fallon
(Address) 1006 Forrest St

15 JUN 28 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1923

17 I HEREBY CERTIFY, That I attended deceased from June, 1922, to June 27, 1923, that I last saw h[illegible] alive on June 26, 1923, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Cardio-vascular-renal disease. (duration) indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E H Hayward M. D.

, 19 (Address) 23 W Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	June 29 1923
20 UNDERTAKER H. C. Friedfeld	ADDRESS 914 Greenmt Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Gousha

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77088

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

D77088

Registered No. C.....

City of BALTIMORE: (No. 1928 Greenmount Ave St. ...Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Paul Gousha

(Residence in Baltimore: No. 711 E. Chase St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH.

..... 1.....
(Month) (Day) (Year)

7-AGE. 57 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Seaman
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE. (State or Country). Poland

PARENTS.

10-NAME OF FATHER. Poland

11-BIRTHPLACE OF FATHER. (State or Country). Russia

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept.

(Address).....

15-Filed JUN 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 27. 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, an
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary)

Duration yrs. mos. ds.

(Signed) M. D.
(Coroner)

1923 (Address) 1659 Ens

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Baltimore DATE OF BURIAL. June 29. 1923

20-UNDERTAKER. J. C. Windsor ADDRESS 1928 Greenmount Ave

Spec.—1-10-21—M&T—1500 Blks.

D77089

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77089

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 63 W. West St., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mary Wheatley

(a) RESIDENCE NO. 63 W. West ST., 23 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
64	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer no employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Peter Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Eugnia Brown

(Address) 63 W West St

15 JUN 28 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/27/1923

17 I HEREBY CERTIFY, That I attended deceased from 6/25/23 to 6/27/23.

that I last saw her alive on 6/27/23.

and that death occurred, on the date stated above, at 6.30 a m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) abt 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical-microscop

(Signed) Geo Walker M. D.

6/27/23 (Address) 908 Eshaw Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	June 29 1923
20 UNDERTAKER John H. Toadvine	ADDRESS 142 W Lee St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77090 — 80 — D77090

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1606 W. Mulberry ST., 14 WARD)

2-FULL NAME Ellen M. Norman

(a) RESIDENCE NO. 1606 W. Mulberry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 6 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: f.

4 COLOR OR RACE: col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year): June 21 1923

7 AGE — Years: ..... Months: ..... Days: 6 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: James E. Norman

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Helen Morine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant: James E Norman
(Address): 1606 W Mulberry St

15 Filed JUN 28 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 27 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1. 1923. to ..... 19..... that I last saw h alive on June 27 1923 and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Dont know.

Heat Exhaustion ? ? ?

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) James M Fauver M. D.

, 19 (Address) 613 N. Carlton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: June 28 1923

20 UNDERTAKER: John H. Toadvine — ADDRESS 142 Mulberry St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Infantile Convulsions
Cause of which is un-
known.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77091

CERTIFICATE OF DEATH.

113 ✓ D77091

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1020 North Whitmore St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Daniel Webster Barnes Jr

(a) Residence No. 1020 North Whitmore St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 10 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug. 11th 1921

7-AGE.	If LESS than 1 day.
1 yrs. 10 mos. 15 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Maryland

PARENTS.

10-NAME OF FATHER Daniel Webster Barnes

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Bessie M. Kelso

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Maryland

14- (Informant) Daniel Webster Barnes

(Address) 1020 North Whitmore ave

15- Filed JUN 28 1923 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 26/1923

17- I HEREBY CERTIFY, That I attended deceased from June 20 1923 to June 26 1923.

that I last saw him alive on June 26 1923

and that death occurred, on the date stated above, at 1130 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis (simple).
from whooping cough

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) M. Bauman and Bond M. D.

6/27, 1923 (Address) 626 N. Gilmor St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Western Cemetery	6/28/23

20-UNDERTAKER.	ADDRESS
Geo. Weber & Son	2503 Edmondson ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77092 ✓ D77092

CERTIFICATE OF DEATH.

102

1-PLACE OF DEATH St Josephs hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 2 WARD)

2-FULL NAME Frank C. Fowler

(a) RESIDENCE NO. 5304 Oakland Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Mamie L Fowler

6 DATE OF BIRTH (month, day, and year) May 23 1873

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mules Riding Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Chestertown (State or country) Md

PARENTS

10 NAME OF FATHER Fowler

11 BIRTHPLACE OF FATHER (city or town) Chestertown (State or country) Md

12 MAIDEN NAME OF MOTHER Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mamie L Fowler (Address) 762 Cokesbury St

15 Filed JUN 28 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1923

17

I HEREBY CERTIFY, That I attended deceased from June 22. 1923, to June 26. 1923.

that I last saw him alive on June 26. 1923.

and that death occurred, on the date stated above, at 2 42 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Streptococcus Empyema

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 6/22/23.

Was there an autopsy? No.

What test confirmed diagnosis? C S S.

(Signed) Harold C Pillsbury M. D.

19 (Address) St Josephs hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chestertown Md.	June 28 1923
20 UNDERTAKER Robt J Turner Inc	ADDRESS 1414 E Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cause Unknown

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77093

CERTIFICATE OF DEATH.

D77093

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1422 N. Gilmor ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Hicks

(a) RESIDENCE. No. 1422 N. Gilmor ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Negro	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Hicks

6 DATE OF BIRTH (month, day, and year) Sept. 12 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) worked with

(c) Name of employer 14 yrs. Day & Island Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs. Sadie C. Lowman (Address) 1422 Gilmor

15 Filed JUN 28 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 23rd, 1923, to June 25th, 1923, that I last saw him alive on June 25th, 1923, and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) 14 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) Ed Bird, M. D.

, 19 (Address) 1422 Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn St

DATE OF BURIAL June 27 1923

20 UNDERTAKER S. H. Brown & Son

ADDRESS 1017 Mary

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77094

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D77094

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE. (No. Bay View St. 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Kelley

(Residence in Baltimore: No. 307 Hanover St St. 11 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

6-DATE OF BIRTH. Unknown ..... 1.....
(Month) (Day) (Year)

7-AGE About 59 yrs. ... mos. ... ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Thos Kelley

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Mary E. Crouch

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant). Mary Graham

(Address) 3708 Fait ave

15- Filed JUN 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 26th 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Brights Disease
Unknown
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Acute Alcoholism
(Duration) yrs. mos. ds.

(Signed) Thos. B. Norton M. D.
Coroner.
June 27 1923. (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Western Cem	6-27 1923
20-UNDERTAKER. Daniel Eaton	ADDRESS 916 Penna ave

Spec.—1-10-21—M&T—1500 Blks.

D77095

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D77095

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1006 S. Sharp ST. 12 WARD)

2-FULL NAME Harry C. Hughes.

(a) RESIDENCE NO. 1006 S. SHarp ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single.

6 DATE OF BIRTH (month, day, and year) Jan. 24, 1872.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51.	5.	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saw Filer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. CO. Md.

PARENTS

10 NAME OF FATHER Dont know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know.

12 MAIDEN NAME OF MOTHER Dont know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont know.

14 Informant Carrie Kotner.

(Address) 1006 S. Sharp St.

15 Filed JUN 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923 to June 27, 1923.

that I last saw him alive on June 26, 1923.

and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical

(Signed) M. L. Steinmayer M.D.

6/27/23 (Address) 600 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery. DATE OF BURIAL: June, 29, 1923.

20 UNDERTAKER: A. E. Evans & Evans ADDRESS: 1433 S. Charles St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77096

REGISTERED NO. D77096

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Saint Josephs Gen/Hosp ST., 24 WARD)

2-FULL NAME Miss Mary E. C. Gardner:

(a) RESIDENCE NO. 133 N Queen St ST., WARD
(Usual place of abode) Martinsburg W. Va.
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 21 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Martinsburg Va

PARENTS

10 NAME OF FATHER A. H. A. Gardner

11 BIRTHPLACE OF FATHER (city or town) Berkeley (State or country) West Va

12 MAIDEN NAME OF MOTHER Mary E Couchman

13 BIRTHPLACE OF MOTHER (city or town) Berkeley Co (State or country) West Va

14 Informant Dr H.S. Gardner
(Address) Martinsburg Va.

15 JUN 28 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1923

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1923, to June 28, 1923, that I last saw h alive on June 28, 1923, and that death occurred, on the date stated above, at 9-29 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes
Hypostatic pneumonia

(duration) 5 yrs. mos da.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John Adamson, M. D.

, 19 (Address) Saint Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Martinsburg W. Va

DATE OF BURIAL: June 28 1923

20 UNDERTAKER: John F. Denny (via Auto)

ADDRESS: 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77097

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77097

CERTIFICATE OF DEATH

REGISTERED NO. C

1 PLACE OF DEATH Foot of 4 1/2 St 182

CITY OF BALTIMORE, No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Luther T. Royster

(Residence in Baltimore: No. 1311 Jefferson st

St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Black

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH. Unknown, 1 .....
(Month) (Day) (Year)

7-AGE. About 36 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer). ....

9-BIRTHPLACE. (State or Country), N C

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country). "

12-MAIDEN NAME OF MOTHER "

13-BIRTHPLACE OF MOTHER (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Luther T. Royster

(Address) 1311 Jefferson St

15- JUN 28 1923 Filed ..... 192.... ROBERT P. KRAUTH, Registrar.
Burial Permit Work.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 25, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained thereat (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. B. Hatton M. D.
(Coroner)

June 26 1923 (Address) Curtis Bay

*State the DISEASE CAUSING DEATH, or, if death was by VIOLENCE, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Lyons Pt C

DATE OF BURIAL. June 25, 1923

20-UNDERTAKER Wm R. Elliott

ADDRESS Ashland Ave

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D77098

HEALTH DEPARTMENT--CITY OF BALTIMORE

D77098

CERTIFICATE OF DEATH

100-001

REGISTERED NO. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 654 Cokesbury ave WARD 9th)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Robert Elmer Sears.

(Residence in Baltimore: No. 654 Cokesbury ave St.; yrs. mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~SINGLE, MARRIED, WIDOWED OR DIVORCED~~ (Write the word): Single

6 DATE OF BIRTH: Feb (Month) 10 (Day), 1907 (Year)

7 AGE: ..... yrs. ..... mos. 14 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George Wesley Sears

11 BIRTHPLACE OF FATHER (State or country): U.S.A.

12 MAIDEN NAME OF MOTHER: Grace Ellen Hayman

13 BIRTHPLACE OF MOTHER (State or country): USA

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George W. Sears

(Address) 654 Cokesbury Ave

15 JUN 28 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Feb (Month) 24 (Day), 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20, 1921, to Feb 24 1921, that I saw him alive on Feb 24, 1921, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

1 Broncho-Pneumonia.

(Duration) ..... yrs. ..... mos. * ds

Contributory (SECONDARY) Pulmonary Atelectasis

(Duration) ..... yrs. ..... mos. ✓ ds.

(Signed), Howard E. Woodley M. D.

....., 1921 (Address) 5306 North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. | In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL OR REMOVAL: Holy Cross | DATE OF BURIAL: Feb 25 1921

20 UNDERTAKER: E. A. Wiedefeld Jr. | ADDRESS: 501 E 22 St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHERE DEATH IS A PERMANENT RESIDENT

Spec.—1-10-21—M&T—1500 Bks.

D77099 HEALTH DEPARTMENT—CITY OF BALTIMORE D77099

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 N Central Ave ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Gold

(a) RESIDENCE No. 305 N Central Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Riffka Lena Gold

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 67; Months; Days; If LESS than 1 day, ...hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): 180

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Abraham Gved

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Sarah Yagoden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): J. Lewis 1439 E. Baltimore St.

15 Filed .19.... ROBERT R. KRAUTER, Registrar

JUN 28 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/28 1923

17 I HEREBY CERTIFY, That I attended deceased from May 14 .1923. to June 28 .1923.

that I last saw him alive on June 28 .1923.

and that death occurred, on the date stated above, at 29 m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

6-28, 1923 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery Ave. DATE OF BURIAL: June 25 1923

20 UNDERTAKER: Krt Lewis ADDRESS: 1439 E Balto

N. B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D77100 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77100

CERTIFICATE OF DEATH. 1923

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Mrd Hospital St., 22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Vernon Kerr. 8

(Residence in Baltimore: No. 432 Iceland St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Col	Single

6-DATE OF BIRTH. unknown ....., 1..... (Month) (Day) (Year)

7-AGE. 30 yrs. mos. ds. — If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Labor
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Kingston Jamaica

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country). Kingston Jamaica

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Kingston Jamaica

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) addie Matthews

(Address) 432 Iceland st

15- JUN 28 1923 Filed 19.. ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 26 23 (Month) (Day) 192.. (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide
Gun Shot Wound.

(Duration) ..... yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia Double Lobular

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. L. C. Rhodes M. D.

(Coroner.)

June 28 23 (Address) 1 E Lexington

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn Cemetery — DATE OF BURIAL, June 29 1923

20-UNDERTAKER. Jno. G. Hooker — ADDRESS 1611 W. Conway st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

body at city morgue

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77101

CERTIFICATE OF DEATH.

90

D77101

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 520 Dover st ST., 27 WARD)

2-FULL NAME Frogs Hotel-

(a) RESIDENCE NO. 520 Dover st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colo	Dont Know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
/	90			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Dont Know

PARENTS

10 NAME OF FATHER — —

11 BIRTHPLACE OF FATHER (city or town) (State or country) — —

12 MAIDEN NAME OF MOTHER — —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant (Address) Home

15 Filed JUN 28 1923 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) yrs. Dont Know mos. ds.

CONTRIBUTORY (Secondary) old age

(duration) yrs. mos. ds.

(Signed) H. F. Swan, M. D.

6-27 1923 (Address) 1 W Dover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL JUN 28 1923

20 UNDERTAKER Commissioner Health.

ADDRESS

MORGUE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D77102

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77102

CERTIFICATE OF DEATH.

X 113

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST., 21 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Miller

(a) RESIDENCE NO. 518 S. Fremont ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3rd. 1922

7 AGE — Years: — Months: 11 — Days: 22 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): N. J.

PARENTS

10 NAME OF FATHER: Louis Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Cora Leatherberry

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. J.

14 Informant: Louis Miller
(Address): 518 S. Fremont Ave

15 Filed ..... 19 ..... Robert P. Harrison, Registrar
JUN 28 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/27 1923

17 I HEREBY CERTIFY, That I attended deceased from 6/25, 1923, to 6/27, 1923.
that I last saw him alive on 6/27, 1923,
and that death occurred, on the date stated above, at 10:50 A. m.

The CAUSE OF DEATH* was as follows:

Uric-Colitis

(duration) ... yrs. mos 28 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) ... yrs. ... mos. 3. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no clinical.

What test confirmed diagnosis?

(Signed) Leon Friedman, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: 7/28 1923

20 UNDERTAKER: Liston C. Fusselbaugh — ADDRESS: 2620 St. Paul

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77103 ✓D77103

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH

REGISTERED No.....

CITY OF BALTIMORE: (No. 412 Fountain Ave ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Lenering

(a) RESIDENCE. No. 412 Fountain Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? — yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stella Lenering

6 DATE OF BIRTH (month, day, and year) May 24 1889

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
33 yrs.	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electric Light Repair man

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bal. Gas. Electric Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jos. L. Lenering

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Wahl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Amelia R. Scott

(Address) 1121 Eastern Ave.

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

N 28 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1 1923, to June 26, 1923, that I last saw h.. alive on June 25, 1923, and that death occurred, on the date stated above, at 4.45 p.m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatic fever (duration) yrs. mos. 8 ds.

CONTRIBUTORY (secondary) Acute endocarditis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. T. Hennessy, M. D.

(Address) 253 Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREATION OR REMOVAL	DATE OF BURIAL
London Park	June 29 1923

20 UNDERTAKER Geo. L. Schwab ADDRESS 1101 Fredk. Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77104

CERTIFICATE OF DEATH.

129 D77104

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1820 E. Monument ST.: 7 WARD)

2-FULL NAME Albert W. Schoennagel

(a) RESIDENCE. No. 1820 E. Monument ST., 7 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Mary Schoennagel

6 DATE OF BIRTH (month, day, and year) June 11 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66		15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horse Shoer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

936

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Albert Schoennagel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Marie Schoennagel 1820 E. Monument St

15 Filed JN 28 1923 (Robert P. Harrison) Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1923

17

I HEREBY CERTIFY, That I attended deceased from June 22, 1923, to June 26, 1923, that I last saw h in alive on June 26, 1923, and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

June 27, 1923 (Address) 2005 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 29 1923

20 UNDERTAKER Wm. H. Schaeffer ADDRESS 1816 Monum

MAKE ENTRY—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77105

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hospital St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Pauline A. Rider

(Residence in Baltimore: No. 3008 E. Monument St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	Single

6-DATE OF BIRTH. Feb. 25/1920 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
3 yrs. 4 mos. 1 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Phila. Pa.

PARENTS.

10-NAME OF FATHER. Osborne L. Rider

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Agnes C. Brannan

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O.L.Rider

(Address) 3008 E. Monument St.

15- JUN 28 1923 Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 26/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

PROBABLY- Toxemia due to gastro-intestinal absorption. (history of several weeks "indigestion")

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. H. Davis M. D.
(Coroner)

6/28/23 1923 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. New Cathedral DATE OF BURIAL. June 29 1923

20-UNDERTAKER. William G. Schaeffer ADDRESS 816 Monument

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D77106

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77106

CERTIFICATE OF DEATH.

Registered No. C 170

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. General Hospital St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Flora C. Boyer

(Residence in Baltimore: No. 1422 Madison Ave. St.; yrs. 30 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

6-DATE OF BIRTH. May 20th 1857
(Month) (Day) (Year)

7-AGE. 36 yrs. 1 mos. 7 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). England

PARENTS.

10-NAME OF FATHER. Alonzo H. Groesbeck

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Mary E. Mitchell

13-BIRTHPLACE OF MOTHER, (State or Country). England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles H. Boyer

(Address) Phoebes, Va.

15- Filed ....., 192.... Robert P. Harrison, Registrar.

JUN 28 1923 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 27th 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ....., (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Sarcoma of Duodenum
Contributory Cancer of Stomach

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

June 28 1923 (Address) 2502 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cem. DATE OF BURIAL. June 29 1923

20-UNDERTAKER. Joseph B. Cook ADDRESS. 1003 W. Balto St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

COPY

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77107

CERTIFICATE OF DEATH.

D77107

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1316 W. Lanvale ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabel Brooks Thompson

(a) RESIDENCE NO. 1316 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Thompson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	76	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Anna T. Bean (Address) 1316 W. Lanvale St.

15 Filed JUN 28 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 - 1923

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1923, to June 28, 1923, that I last saw her alive on June 28, 1923, and that death occurred, on the date stated above, at 7.20 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Geo. W. Kemp M. D.

(Address) 300 E Harrison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem.	June 30 1923

20 UNDERTAKER Harry W. Ehlen ADDRESS 1944 W. Norths

IN 28 1923

GE THE INFORMATION REQUESTED. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77108

CERTIFICATE OF DEATH.

1923 D77108

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2404 Rosleyn Ave St., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Kendall Botelar

(a) RESIDENCE NO. 2404 Rosleyn ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eleanor R Forsh Botelar

6 DATE OF BIRTH (month, day, and year): June 14 1839

7 AGE: Years 84 Months 5 Days 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Builder

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country): Georgetown D C

PARENTS

10 NAME OF FATHER: Jos I Botelar

11 BIRTHPLACE OF FATHER (city or town) (State or country): Georgetown D C

12 MAIDEN NAME OF MOTHER: Ellen Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): D C

14 Informant: Virginia Botelar
(Address) 2404 Rosleyn

15 Filed: June 28 1923 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26 1923

17

I HEREBY CERTIFY, That I attended deceased from 22 June, 1923, to 26th June 19.

that I last saw him alive on 26th June, 1923, and that death occurred, on the date stated above at 1030 P.M.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) 60 days mos. ds.

CONTRIBUTORY (Secondary) Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? City

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) H. F. Hill, M. D.

, 19 (Address) 1208 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: June 29 1923

20 UNDERTAKER: Wm J Sudler & Son — ADDRESS: Baltimore

JUN 28 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Dr. K. A. Hall

Madison Ark

1208

Heat prostration.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77109

CERTIFICATE OF DEATH.

91-002

D77109

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 E Cross ST., 24 WARD)

2-FULL NAME Mary Louise Moran

(a) RESIDENCE NO. 27 E Cross ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
about 8			

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co. Md.

PARENTS

10 NAME OF FATHER Robt Hankins

11 BIRTHPLACE OF FATHER (city or town) (State or country) A. A. Co Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Ella Robbins

(Address) 27 E Cross

15 Filed JUN 28 1923 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1923

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1923 to June 27, 1923.

that I last saw h alive on June 26, 1923.

and that death occurred, on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Cardiac Collapse

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harry Jones M. D.

(Address) 6 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Waverly A. A. Co. Md

DATE OF BURIAL June 27 1923

20 UNDERTAKER W. J. Tickener & Sons

ADDRESS North Ave

I.B.—WRITE PLAINLY, WITH UNFADING INK—THIS DEPARTMENT REQUIRES EXACT INFORMATION. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77110 D77110

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2425 Madison Ave. ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Eliza Merritt

(a) RESIDENCE NO. 2425 Madison Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 11th 1885

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
37	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Alonza I. Merritt

11 BIRTHPLACE OF FATHER (city or town) A.A.Co. (State or country) Md.

12 MAIDEN NAME OF MOTHER Sophia A. Heyn

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Martin H. Merritt (Address) 2425 Madison Ave.

15 Filed Robert P. Harrison, Registrar

Postal Card Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28th 1923

17

I HEREBY CERTIFY, That I attended deceased from September 1921 to June 28 1923, that I last saw her alive on June 28 1923, and that death occurred, on the date stated above, at 5.02 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Syncope

about 4 hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis
Chronic
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) G. Lebrohe Ecroll M. D.

6/28 1923 (Address) 2945 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	June 29 1923
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W. Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77111

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77111

CERTIFICATE OF DEATH. 161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1652 N Smallwood ST., 8 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Shapiro

(a) RESIDENCE NO. 1652 N. Smallwood ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 6-26-23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm Shapiro

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Annie Abrams

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Annie Shapiro
(Address) 1652 N. Smallwood

15 JUN 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-28-1923

17

I HEREBY CERTIFY, That I attended deceased from 6-26-, 1923, to 6-28-, 1923,

that I last saw him alive on 6-27-, 1923,

and that death occurred, on the date stated above, at 4 00 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Chester Richard, M. D.

6-28-1923 (Address) 2552 Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [redacted] DATE OF BURIAL 6-30-23

20 UNDERTAKER M. J. Lennon ADDRESS 429 E. Baltimore St

(1) Full name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77112

CERTIFICATE OF DEATH.

96 D77112

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Brown

(a) RESIDENCE NO. 1194 Clinton St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) ~~WIFE~~ of Carrie Brown.

6 DATE OF BIRTH (month, day, and year) Oct 14th 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothing cutter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Joseph L Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Sarah Britton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Carrie Brown

(Address) 119 S Clinton St

15 JUN 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1923

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1923, to June 27, 1923, that I last saw him alive on June 27, 1923, and that death occurred, on the date stated above, at 6.50 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.

Duration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Aortic Regurgitation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. A. Schenvich, M. D.

, 19 (Address) St. J. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	6/28 1923
20 UNDERTAKER Bott & Turner Inc	ADDRESS 1444 E Broadway

INSTRUCTIONS—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77113

CERTIFICATE OF DEATH.

31 ✓ D77113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 555 Greenmount ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Viola Ray

(a) RESIDENCE NO. 555 Greenmount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 6 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 8th 1912

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
10 yrs	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Florence Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Florence Ray

(Address) 555 Greenmount Ave

15 Filed JUN 29 1923, 19 ROBERT R. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1923

17 I HEREBY CERTIFY, That I attended deceased from April 26th, 1923, to June 27th, 1923.

that I last saw her alive on June 26th, 1923,

and that death occurred, on the date stated above, at 2.50 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (duration) - yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) Pleurisy (duration) yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? Greenmount Ave & Wells

Did an operation precede death? No Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Examination & Sputum

(Signed) Edward Ellacheniz, M. D.

June 27, 19 (Address) 1339 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	June 29 1923

20 UNDERTAKER Brown Sisk and Dickson ADDRESS 1141 N.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77114

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D77114

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Hillman ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine A. Lupton

(a) RESIDENCE No. 1014 Hillman ST., 10 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of the late Edward Lupton.

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New Windsor Md

PARENTS

10 NAME OF FATHER: Anthony Hazett.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Annie Hazett.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Mrs. Elizabeth Donovan
(Address) 1014 Hillman St

15 JUN 29 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1923

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1922, to June 27, 1923, that I last saw h[illegible] alive on June 26, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis & Endocarditis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Typical Symptoms

(Signed) Hugh. Grayot, M. D.

June 29, 1923 (Address) 22 E. Mt. Vernon Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: June 30 1923

20 UNDERTAKER: Henry Hoeck & Son — ADDRESS: 1301 E Eager St

N.B.—WRITE PLAINLY, WITH PENCIL OR PEN AND INK. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77115

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77115

CERTIFICATE OF DEATH.

57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 816 S. Streeper ST., 1 WARD)

2-FULL NAME Rosemary Cunningham

(a) RESIDENCE NO. 816 S. Streeper ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 27th 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	12			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School attendant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER James Cunningham

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary Volcke.

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant Mary Schimmels

(Address) 816 S. Streeper St.

15 JUN 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1923

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1923. to June 26. 1923.

that I last saw h[illegible] alive on June 26, 1923.

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Diabetic Mellitus

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Gibson, M. D.

June 27 1923 (Address) 80 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	June 30th 1923
20 UNDERTAKER	ADDRESS
Lilly-Zeiler	4008 Wash. Blvd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D77116

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77116

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1003 Leadenhall St. ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME M. Ernestine Jobes. (C).

(a) RESIDENCE NO. 1003 Leadenhall St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 7 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) November 20, 1920.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	7	8.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Jobes. (C).

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Eleanore Clash. (C).

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Eleanore Jobes. (C).

(Address) 1003 Leadenhall St.

15 FILED JUN 29 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner)

June 29, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	June 29 1923
UNDERTAKER	ADDRESS
J. W. Brown & Son	1525 Pennsylvania

GE should be stated EXACTLY. PHYSICIANS should state
at it may be properly classified. Exact statement of OCCUPA-
on back of certificate.

mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it
TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks.

D77117

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D77117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1303 myrtle ave. ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Maudie Campbell

(a) RESIDENCE NO. 1303 myrtle Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Campbell

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Albert R. Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore County

12 MAIDEN NAME OF MOTHER Laura Banks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore County

14 Informant Bernard Mason (Address) 1303 Myrtle ave.

15 Filed JUN 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1923, to June 26, 1923, that I last saw h w alive on June 26, 1923, and that death occurred, on the date stated above, at 8.30 p. m.

The CAUSE OF DEATH* was as follows:

Cancer of cervix

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw J. Wheeler, M. D.

(Address) 1225 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 27 1923

20 UNDERTAKER Wm R. S. Elliott ADDRESS 1727 Eutaw Pl.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77118 117 D77118

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2004 Hunter St., 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louie Cheeman

(a) RESIDENCE No. 2004 Hunter St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	C.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 6 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Public Wok

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Unknown 0+0

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Louis Cheeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Annie Cheeman

(Address) 2004 Hunter St

15 Filed JUN 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1923

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1923, to June 24, 1923, that I last saw h— alive on June 24, 1923, and that death occurred, on the date stated above, at 4:00 P m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis and Local peritonitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Gun shot wound

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? institution

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Obs

(Signed) Ad L Hall, M. D.

, 19 (Address) 1266 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL June 27 1923

20 UNDERTAKER Mrs. R. C. Elliott — ADDRESS 17 Eastland

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77119

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77119

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. U.S. Marine Hosp. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hans Boettger

(Residence in Baltimore: No. U.S. Marine Hosp No 6 St.; yrs., mos. 14 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH, Unknown (Month) (Day) 1 (Year)

7-AGE, 23 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer) do

9-BIRTHPLACE, (State or Country) Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country) Germany

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) U.S.M. Hosp no 1

(Address) Pennington Ave

15- JUN 29 1923 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 28 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH was as follows:

Fracture Base of Skull
Accidental

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John J. Morris M. D. (Coroner.)

June 29, 1923 (Address) 2032 Reisterstown Rd

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Germany

19-PLACE OF BURIAL OR REMOVAL, Trinity Cemetery — DATE OF BURIAL, 8/29 1923

20-UNDERTAKER, A. Leimsner & Bro — ADDRESS 1127 E Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

16466 3
12 10 A.M.

Pt. has been in Balto for 25 years

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77120

CERTIFICATE OF DEATH.

84 D77120

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Russel Gates

(a) RESIDENCE No. 4164 Belair Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE~~ Mary Wallace Gates

6 DATE OF BIRTH (month, day, and year) March 5, 1894

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
29	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer) 1

(c) Name of employer Bartlett & Hayward

9 BIRTHPLACE (city or town) (State or country) Lebanon, Penna

PARENTS

10 NAME OF FATHER Harry H Gates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lebanon Penna

12 MAIDEN NAME OF MOTHER Alice Eliz. Phillippy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lebanon Penna

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed JUN 29 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1923

17

I HEREBY CERTIFY, That I attended deceased from June 13, 1923, to June 28, 1923, that I last saw h alive on June 28, 1923, and that death occurred, on the date stated above, at 12:10 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor (glioma)

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of June 27-1923

Was there an autopsy? Yes - Partial

What test confirmed diagnosis?

(Signed) Warfield M. Firor, M. D.

6/28. 1923 (Address) John Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL July 2 1923

20 UNDERTAKER John Ullrich

ADDRESS 200 Aisquith

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ENTRY of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77121

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

19 31 ✓ D77121

Registered No. C.....

City of BALTIMORE: (No. 1502 Saraann St., 19 Ward)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Rose Dorsey

(Residence in Baltimore: No 1502 Saraann St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Femal

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word) Marred

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1893 (Year)

7-AGE. 29 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....mln.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. H Worker
(b) General nature of industry, business, or establishment in which employed (or employer). Home

9-BIRTHPLACE, (State or Country). Baltimd

PARENTS.

10-NAME OF FATHER. James Green

11-BIRTHPLACE OF FATHER, (State or Country). md

12-MAIDEN NAME OF MOTHER. Mayallen

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm B Dorsey

(Address) 1502 Saraann

15-

Filed JUN 29 1923 ROBERT R. KRAUTER Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 28 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to Hir death on the day stated above.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

.....(Duration) ..... yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Fenton M. D (Coroner)

June 28 1923 (Address) 701 E Chase St

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cem — DATE OF BURIAL. 6-29 1923

20-UNDERTAKER. Daniel Easton — ADDRESS 916 Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D77122

D77122

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 N. Fulton Ave ST.; 20 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Hucorn

(Residence in Baltimore: No. Home for Aged of the M.E Church St.; ..... yrs., Life mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, October (Month) 20 (Day), 1834 (Year)

7-AGE, 88 yrs. 8 mos. 8 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Hucorn

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Mary E Thomas

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Harlen Eddy

(Address) 400 N. Fulton

15- Filed JUN 29 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 28 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from March 2 1920, to June 28 1923, that I saw h[er] alive on June 26 1923, and that death occurred, on the date stated above, at 4.30 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(Duration) — yrs. — mos. 8 ds.

(Signed) George C. Shannon M. D.

June 29, 1923 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mount Olivet — DATE OF BURIAL, June 30, 1923

20-UNDERTAKER George J. Smith — ADDRESS 1532 Pulaski St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1509 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77123

CERTIFICATE OF DEATH. 162 D77123

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1729 Poshuy St., 15 Ward)

2-FULL NAME Infant Samuel & Emily Johns

(a) RESIDENCE NO. 1729 Poshuy St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26th 1923

7 AGE — Years — Months — Days: 1 — If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): City

(State or country)

PARENTS

10 NAME OF FATHER: Samuel Johns

11 BIRTHPLACE OF FATHER (city or town): City

(State or country)

12 MAIDEN NAME OF MOTHER: Emily Denk

13 BIRTHPLACE OF MOTHER (city or town): City

(State or country)

14 Informant: Samuel Johns

(Address) 1729 Poshuy St.

15 JUN 29 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-27- 1923

17 I HEREBY CERTIFY, That I attended deceased from 6-27- , 1923 , to 6-27- , 1923 , that I last saw h[illegible] alive on 6-27- , 1923 , and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Strangulation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Collection of mucous

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) George C. Rye, M. D.

, 19 (Address) 1700 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cemetery — DATE OF BURIAL: June 29 1923

20 UNDERTAKER: Hamme & Wright — ADDRESS: 1364 W. Cary

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77124 D77124

CERTIFICATE OF DEATH. X101-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Lee

(a) RESIDENCE. NO. Turner Station Baltimo WARD. Cambridge Md

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. 23 mos. — ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE Colored

5 Single, ~~Married, Widowed, or Divorced~~ (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE 18 Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Steel

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jacues Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Winn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Chas. Klein

(Address) Turner Station

15 JUN 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-27- 1923

17 I HEREBY CERTIFY, That I attended deceased from 6-27 1923, to 6-28 1923, that I last saw h[illegible] alive on 6-27 1923, and that death occurred, on the date stated above, at 2. a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

7 days (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George C. Page, M. D.

, 19 (Address) 170 N. Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carrollton DATE OF BURIAL June 29 1923

20 UNDERTAKER Edward Bryan ADDRESS 1631 Orleans

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AGE should be carefully supplied.

Spec.—1-10-21—M&T—1500 Bks.

Hauser.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77125

CERTIFICATE OF DEATH.

174-001 D77125

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1735 Light ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob N. Hauser

(a) RESIDENCE NO. 1735 Light ST., 174 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hauser

6 DATE OF BIRTH (month, day, and year) May 10 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or..... min.
	67	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

040

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Geo H Hauser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine Franke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs Hauser (Address) 1735 Light St

15 FILED JUN 29 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1923

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1923 to June 27, 1923

that I last saw him alive on June 27, 1923

and that death occurred, on the date stated above, at 7-40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. F. Campbell M. D.

June 30, 1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 6/30 1923

20 UNDERTAKER J. Fahey Howe — ADDRESS 138 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77126

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77126

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH John Hopkins Hosp. REGISTERED NO.

CITY OF BALTIMORE (No. 307 N. Exeter ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Carnabuci.

(a) RESIDENCE No. 307 N. Exeter ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 10, 1923

7 AGE: Years — Months — Days — If LESS than 1 day, hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Carnabuci

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Fantacre

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Johns Hopkins Hospital

15 Filed JUN 29 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1923. to June 10, 1923. that I last saw him alive on June 10, 1923. and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Intra uterine asphyxia

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W W Gray, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Commissioner Health,

Dr. Wm. S. Randall

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

84

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77127

CERTIFICATE OF DEATH.

X 185 D77127

1-PLACE OF DEATH

City of BALTIMORE (No.) Maryland General Hospital

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Keller Jr.

(Residence in Baltimore: No. Ellicott City, Md. St.; yrs. mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Single

6-DATE OF BIRTH. Dec. 11 1904
(Month) (Day) (Year)

7-AGE. 18 yrs. 6 mos. 17 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Charles H. Keller

11-BIRTHPLACE OF FATHER, (State or Country) Maryland

12-MAIDEN NAME OF MOTHER. Mary A. Gaither

13-BIRTHPLACE OF MOTHER, (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles H. Keller
(Address) Ellicott City Md.

15-
Filed JUN 29 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June 25 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.)
find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured neck
accidental Drowning

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)
(Duration) yrs. mos. ds.

(Signed) C. E. Hammond M. D.
(Coroner)
June 28 1923 (Address) 285 Fawcett Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. St. Paul Cem. DATE OF BURIAL. June 30 1923.

20-UNDERTAKER. Easton Sons ADDRESS Ellicott City

D77128

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D77128

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2302 Jefferson St. St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Marshall

(Residence in Baltimore: No. 2302 Jefferson St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	Widowed

6-DATE OF BIRTH. May (Month) 24 (Day) 1855? (Year)

7-AGE. 68 yrs. 1 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Watchman.
(b) General nature of industry, business, or establishment in which employed (or employer): Garage 062

9-BIRTHPLACE, (State or Country). Balto .Md.

PARENTS:

10-NAME OF FATHER. Steve Marshall

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Matilde Sincler

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Marshall Jr.

(Address) 161 N. Potomac St.

15- Robert P. Harrison, 192.....

Burial Permit Clerk. Registrar.

JUN 29 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 27/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insuffiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma

(Duration) 20 yrs. mos. ds.

(Signed) J S Heller M. D. (Coroner)

6/28/23 192.... (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Oak Lawn Cem DATE OF BURIAL. June 30 1923

20-UNDERTAKER. Jos J. Herr & Son ADDRESS 1566 N. Luzerne

(Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Spec—12-23-21—E.B.R.S.—400 Bks.

D77129

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12-002 D77129

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3042 Greenmount Ave St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simon Zepp

(a) Residence No. 3042 Greenmount Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, ~~HUSBAND~~ of (or) WIFE of Catherine Zepp

6-DATE OF BIRTH (month, day and year) April 22 1869

7-AGE. 54 yrs. 2 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer.....

9-BIRTHPLACE (city or town), (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Ezra Zepp

11-BIRTHPLACE OF FATHER (city or town), (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Catherine Hahn

13-BIRTHPLACE OF MOTHER (city or town), (State or Country), Maryland

14- (Informant) Catherine Zepp

(Address) 3042 Greenmount Ave

15- Filed ..... 19.... Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 28. 23

17- I HEREBY CERTIFY, That I attended deceased from October 14 1922 to June 28 1923 that I last saw him alive on June 27 1923 and that death occurred, on the date stated above, at 1-30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular disease of Heart

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W S Gibson M. D.

(Address) 622 W Mount Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore — DATE OF BURIAL. June 30 1923

20-UNDERTAKER. Josiah Lyter — ADDRESS 1600 W. North Ave

Burial Permit Clerk.

IMPORTANT—WRITE PLAINLY, with UNFADING INK. Every answer should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms): *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Non-Alcoholic

Spec—12-23-21—E.B.R.S.—400 Bks.

D77130

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77130

CERTIFICATE OF DEATH.

Registered No. 31

1-PLACE OF DEATH

City of BALTIMORE: (No. 2712 Penna-Ave St., 15 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Herman St. Gregory Spitznagel

(a) Residence No. 2712 Pennsylvania Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, married Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Anna May Spitznagel

6-DATE OF BIRTH (month, day and year) Jan. 20. 1892

7-AGE. 31 yrs. 5 mos. 8 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk 004

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Max Spitznagel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna Frederick

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Anna Spitznagel (Address) 2712 Penna Ave

15- Robert P. Harrison, Burial Permit Clerk

JUN 29 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 28. 23.

17- I HEREBY CERTIFY, That I attended deceased from June 20, 1923 to June 27, 1923 that I last saw h~~e~~ alive on June 28 1923 and that death occurred, on the date stated above, at 1-30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY, (Secondary) Chronic Laryngitis.

(Duration) x yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Bernard P. Sunst M. D.

6/29, 1923 (Address) 1707 Eastern Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral Cem. DATE OF BURIAL, July 2 1923

20-UNDERTAKER. Jacob Dyfer ADDRESS 1600 W. North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77131 ✓ 001 D77131

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 12 Woodlawn Road ST.; 27th WARD) REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Burleigh Hollijes

(Residence in Baltimore: No. 121 Woodlawn Road St.; 18 yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Married

6-DATE OF BIRTH, November 18th (Month), 1875 (Day) (Year)

7-AGE, 44 yrs. 7 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Camden, N. J.

PARENTS.

10-NAME OF FATHER, John J. Burleigh

11-BIRTHPLACE OF FATHER (State or Country), Salem N. J.

12-MAIDEN NAME OF MOTHER Anna Heighton Smith

13-BIRTHPLACE OF MOTHER (State or Country), Elmer N. J.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Henry D. Hollijes

(Address) 121 Woodlawn Road

15- Robert F. Harrison,

....., 191.....

JUN 29 1923 Burial Permit Clerk Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 29 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13 1923, to June 29 1923, that I saw h[er] alive on June 29 1923, and that death occurred, on the date stated above, at 11:55 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Hemorrhage

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) General arterio-sclerosis

(Duration) 10+ yrs. ....mos. ....ds.

(Signed) M. Milton Portis M. D.

6/29, 1923. (Address) 422 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Churchville N. J. DATE OF BURIAL, June 2, 1923

20-UNDERTAKER J. Block ADDRESS 1013 W. Balto St.

NOTE.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77132

CERTIFICATE OF DEATH.

182 D77132

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Off Wagner's Point. ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Anuszewski.

(a) RESIDENCE NO. 81 Third Ave. ST., Wagner's Point. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) October 2, 1918.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	4	8	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Andrew Anuszewski.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Cecelia Bialeozka. Bialecki

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Andrew Anuszewski. (father). (Address) 81 Third Ave. Wagner's Point

15 Filed JUN 29 1923 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Accidental fall into water from a wharf. (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M Reinhardt, M. D. (Coroner.)

June 29, 192 3 (Address) 1017 E. Chatles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	June 30 1923
20 UNDERTAKER	**ADDRESS**
John M Weber	1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificate.

(Nelson)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77133 X 90 D77133

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Union Station G. W. Tower 17 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gilbourn H. Nelson

(Residence in Baltimore: No. — White Hall, Md St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH.

..... 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
5-4 yrs. mos. ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Rail Operator
(b) General nature of industry, business, or establishment in which employed (or employer): R.R.

9-BIRTHPLACE, (State or Country): Md.

PARENTS:

10-NAME OF FATHER: Robt. Nelson

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Margt. Hunter

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. E. Hunter

(Address) 1293 8 W. North Ave

15- Filed N 29 1923 Robert F. Harrison, 192 Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. June (Month) 29 (Day) 1923 (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fatal dis. Heart

Sudden (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. J. Bailey M. D. (Coroner.)

June 29 1923 (Address) 1639 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Vernon Cem. White Hall, Md June 2 1923

20-UNDERTAKER P. Madeline Son ADDRESS White Hall Md

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77134

CERTIFICATE OF DEATH.

74-00 D77134

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3115 Foster Ave. ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Graham

(a) RESIDENCE No. 3115 Foster Ave. ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. - mos. - ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) ---

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	79	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer ---

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Ann Bean

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Harry C. Sanner

(Address) 300 Woodlawn Road, R. F.

15 Filed JUN 29 1923 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1922 to June 28, 1923, that I last saw h[illegible] alive on June 28, 1923 and that death occurred, on the date stated above, at 7:40 P. m.

The CAUSE OF DEATH* was as follows:

Arteio Sclerosis
uremia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(Terminal) (duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? o

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M. J. McAvoy, M. D.

6/29 1923 (Address) 839 S. Ellwood Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL June 30/23

20 UNDERTAKER Henry W. Mears & Son,

ADDRESS 805 Calvert

Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77135

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77135

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Park Ave & Glenmore St. Ward 21)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Elizabeth Anderson

(a) RESIDENCE NO. Park Ave & Glenmore St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. W.

6 DATE OF BIRTH (month, day, and year) July 27 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10 NAME OF FATHER Geo. W. Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Wiley.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo. W. Anderson (Address) Park Ave & Glenmore

15 Filed N 29 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1923

17

I HEREBY CERTIFY, That I attended deceased from 6/17 1923, to 6/21 1923, that I last saw h alive on 6/21 1923, and that death occurred, on the date stated above, at 11-15 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual tests for sugar

(Signed) Albert E. Mac Crum, M. D.

, 19 (Address) 3612 Liberty Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	July 3 1923

20 UNDERTAKER Wm Corby & Sons ADDRESS 2212 W. Lex

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-16-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77136 ✓ 129 D77136

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 945 Montpelier Av St. WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie Eaton.

(a) RESIDENCE No. 945 Montpelier Av St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced HUSBAND (or) WIFE of: Elijah E. Eaton

6 DATE OF BIRTH (month, day, and year): June 25th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick Co Va.

PARENTS

10 NAME OF FATHER: Chandler Hawpe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Winchester Va.

12 MAIDEN NAME OF MOTHER: Rebecca Light

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Co Va.

14 Informant: Mrs. Harry Hardy

(Address) 945 Montpelier St

15 [illegible] 19 .....

Registrar

Robert F. Harrison,

Burial Permit Clerk.

UN 29 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 28th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 19th, 1923 to June 28th, 1923, that I last saw h[illegible] alive on June 28, 1923, and that death occurred, on the date stated above, at 7 0 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) [illegible] M. D.

6/29/23 (Address) 401 E 25th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Winchester Va.

DATE OF BURIAL: 6/30/1923

20 UNDERTAKER: Wm. Cook - 502 E North

ADDRESS

B. WRITE LEGIBLY, WITH UNFADING INK. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D77137

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D77137

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1809 Baker ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jane Matthews

(a) RESIDENCE No. 1809 Baker ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	white	married

5a If married, widowed, or divorced (or) ~~HUSBAND~~ WIFE of Norman Matthews

6 DATE OF BIRTH (month, day, and year) Dec. 23-1852

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
70	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Elliott City

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Brooks

11 BIRTHPLACE OF FATHER (city or town) —

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Griffith

13 BIRTHPLACE OF MOTHER (city or town) ...

(State or country) Maryland

14 Informant Norman Matthews

(Address) 1809 Baker St

15 Filed N 29 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1923

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1923, to June 27, 1923

that I last saw h alive on June 27, 1923

and that death occurred, on the date stated above, at 10.40 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chr Interstitial Nephritis (duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) James Brown, M. D.

6/28 1923 (Address) 1837 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	6/30/1923

20 UNDERTAKER Wm. Cook — 502 E. North Ave

N. B.—WRITE PLAINLY, WITH INDELIBLE INK. Every question should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77138

CERTIFICATE OF DEATH.

46

D77138

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1717 Patterson Park Avenue St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Catherine Dorsch

(a) Residence No. 1717 Patterson Park Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Dorsch

6-DATE OF BIRTH (month, day and year) Sept. 1860

7-AGE. 62 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) City (State or Country).

PARENTS.

10-NAME OF FATHER. Charles George

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Barvaria

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Chas Dorsh

(Address) 1717 Patterson Park

15- Robert P. Harrison, Registrar.

JUN 29 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 27, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 20, 1922 to June 27, 1923

that I last saw her alive on June 26, 1923

and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) 1 yrs. mos. ds

CONTRIBUTORY (Secondary) Acidosis

(Duration) yrs. mos. 3 ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What lesl confirmed diagnosis? Clinical

(Signed) Edw. V. Cookerd. M. D

6/28 1923 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Ho Redeemer Cem	6/30 1923
20-UNDERTAKER. J. A. Moran	ADDRESS 3000 E Balto St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77139

CERTIFICATE OF DEATH.

D77139

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Young.

(a) RESIDENCE NO. 330 Saint Paul ST., WARD Wash. D. C.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): ? 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	70	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ret Soldier

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Miss Mary [illegible] (Address) 1737 - McHenry St

15 Filed 19 Robert F. Harrison, Registrar

JUN 30 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 28 1923

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1923, to June 28, 1923, that I last saw him alive on June 28, 1923, and that death occurred, on the date stated above, at 10 30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Arterio Sclerosis

(duration) yrs. 3 mos. [illegible] ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. W. Ledd M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery — DATE OF BURIAL: June 30 23

UNDERTAKER: Harry H. Witzke — ADDRESS: 1516 Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

KODAK S.A.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cerebral Haemorrhage.

Spec.—1-10-21—M&T—1500 Blks.

D77140

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1279 77140

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6 South Arlington St. (WARD) 18

2-FULL NAME Thomas J. Byron

(a) RESIDENCE NO. 6. S. Arlington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 If Married, Widowed or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Byron

6 DATE OF BIRTH (month, day, and year) Nov. 2nd 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of Industry, business, or establishment in which employed (or employer) W. M. R.R. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newark N.J.

PARENTS

10 NAME OF FATHER John Byron

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ruth Dolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Ida Warthen 6 S. Arlington

15 Filed JUN 30 1923, Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29. 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 20. 1923. to June 29. 1923.

that I last saw him alive on June 28. 1923.

and that death occurred, on the date stated above, at 4 30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease.

(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no. Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Urine Analysis etc.

(Signed) Thos. Corkran, M. D.

, 19 (Address) 888 N. Loudon Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul Cathedral

DATE OF BURIAL 7/2 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E. Mt. St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. (Angie Cousin)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77141 ✓ 129 D77141

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 851 Lemmon ST., 18 WARD)

2-FULL NAME Angie Cousin

(a) RESIDENCE NO. 851 Lemon ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Cousin

6 DATE OF BIRTH (month, day, and year) Unknown 1887

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
36	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS
10 NAME OF FATHER Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Walter Cousin
(Address) 851 Lemmon St

15 Robert F. Harrison, Registrar
N 30 1923 19 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/25 1923

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1923, to June 25, 1923
that I last saw h alive on June 27, 1923
and that death occurred, on the date stated above, at 3 A m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Uraemia
(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Chas A Carlson M. D.
6/25 1923 (Address) 2318 N Bells St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	July 2 1923
20 UNDERTAKER John H. Toadvine	ADDRESS 142 Ostick St

M. WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIAN should state mation should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77142

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77142

CERTIFICATE OF DEATH.

REGISTERED NO. 117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin St. Hospital ST., 45 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leroy Tilghman

(a) RESIDENCE NO. 1319 N. Stricker ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 24 1905

7 AGE: Years 18 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Hezekiah Tilghman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Martha Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Martha Tilghman
(Address) 1319 N. Stricker St.

15 Filed JUN 30 1923, 19 ..... Registrar
Robert P. Harrison.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6 25 1923

17

I HEREBY CERTIFY, That I attended deceased from 6 24 1923, to 6 25 1923,

that I last saw h— alive on 6 25 1923,

and that death occurred, on the date stated above, at 7.00 A m.

The CAUSE OF DEATH* was as follows:

Acute Sup. Appendicitis

(duration) ..... yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Ter. Arteriosclerosis

(duration) ..... yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-20-23

Was there an autopsy? No

What test confirmed diagnosis? Op. findings.

(Signed) W. D. Carr, M. D.

(Address) Franklin St. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wdl Cemetery — DATE OF BURIAL: June 29 23

20 UNDERTAKER: Jacob H. Lund — ADDRESS 1313 Druid

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D77143

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77143

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St. 14 38 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Jones

(a) Residence No. 527 Pressman St St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): 1879

7-AGE. 44 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Foreman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: Wm. Jones

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: Agnes Deshields

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14- (Informant): Municipal Hospital Records

(Address):

15- Filed JUN 30 1923 192 Robert F. Harrison, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 28, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 23 19 23 to June 28 19 23

that I last saw him alive on June 27 19 23

and that death occurred, on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Suppurative Arthritis
Syphilis

(Duration) 20 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (Terminal) (Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Goldsmith M. D.

6-28-23 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville Date of Burial, June 30 19 23

20-UNDERTAKER: James J. Elliott ADDRESS 1103 Druid

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77144

CERTIFICATE OF DEATH.

D77144

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 Bentalow ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. H. Neuhaus

(a) RESIDENCE No. 1103 Bentalow ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 17-1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	22	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agent. 1/1

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. American

(c) Name of employer Fire Inc. Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm. F. H. Neuhaus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna C. Lucke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Wm F. H. Neuhaus

(Address) 1103 Bentalow

15 Filed JUN 30 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1923

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1923 to June 27, 1923, that I last saw him alive on June 24-, 1923 and that death occurred, on the date stated above, at 1 15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis,

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) Marlin W Shook M. D.

6-27-1923 (Address) 806 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Oak Lawn Cemetery June 30 1923

20 UNDERTAKER — ADDRESS

H. Sander's Sons 1710 Pulton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that TION is very important. See instructions

Spec—12-23-21—E.B.R.S.—400 Bks.

D77145 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D77145

CERTIFICATE OF DEATH.

26 124

1-PLACE OF DEATH

City of BALTIMORE: (No. 1115 S. Bouldin St., 26 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Jubb

(a) Residence No. 1115 S. Bouldin St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. 6 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Jubb

6-DATE OF BIRTH (month, day and year) Dec. 20. 1842

7-AGE.	If LESS than 1 day,
81 yrs. 6 mos. 7 ds.	hrs. or min. ?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Conrad Koons

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Not known

12-MAIDEN NAME OF MOTHER, Not known

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Not known

11- (Informant) Mrs. Hensler

(Address) 1115 S. Bouldin St.

15- Albert F. Bartlett,

Filed, 192 Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 27-1923

17- I HEREBY CERTIFY, That I attended deceased from May 26 1923, to June 27 1923, that I last saw h.e alive on June 27 1923, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis Asthma

(Duration) yrs. 16 mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) W. H. Carrington M. D.

6/28, 1923 (Address) 330 N. Bethune St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Carmel Cemetery	June 30, 1923
20-UNDERTAKER, Zirkler - Zirkler	ADDRESS 1739 E Baltimore St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.–Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D77146 PLACE OF DEATH

90 D77146 REGISTERED NO. C

CITY OF BALTIMORE (No. Sterling Sanatorium 7 ST. WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Cuckow.

(Residence in Baltimore: No. 1032 N. Broadway Sterling Sanatorium, 51 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widow

6 DATE OF BIRTH: March 15, 1857 (Month) (Day) (Year)

7 AGE: 66 yrs. 3 mos. 13 ds. If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer): 0

9 BIRTHPLACE (State or country): England

PARENTS

10 NAME OF FATHER: Alex. Ferrie

11 BIRTHPLACE OF FATHER (State or country): England

12 MAIDEN NAME OF MOTHER: Carrie Rossiter

13 BIRTHPLACE OF MOTHER (State or country): England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Jessie Meiberk
(Address): 1032 N. Broadway

15 Filed ... 1923 ... Robert E. Lee ... REGISTRAR

UN 30 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June 28, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May ... 1923 to June 28 1923 that I saw h.. alive on June 28 ... 1923 and that death occurred, on the date stated above, at 8 30 p m.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) yrs. 3 mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Marshall Burst M. D.

June 29, 1923 (Address) Catonsville

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. 1½ mos. ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? Balto

Former or usual residence Balto

19 PLACE OF BURIAL OR REMOVAL: Baltimore

DATE OF BURIAL: June 30 1923

20 UNDERTAKER: Fierkler & Fierkler

ADDRESS 1739 E. Eager

Spec.—1-10-21—M&T—1500 Blks.

D77147

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77147

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 N Carrollton Ave., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dailey

(a) RESIDENCE NO. 112 N Carrollton Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Carrie Dailey

6 DATE OF BIRTH (month, day, and year) April 16, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Elkridge Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Gladys Johnson

(Address) 112 N Carrollton Ave

15 Filed JUN 30 1923, 19 Robert T. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923. to June 28. 1923.

that I last saw him alive on June 27. 1923

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Valvulitis

(duration) Indefinite mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. T. Howell M. D.

1923 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	June 30 1923

20 UNDERTAKER Mrs J. G. Locks ADDRESS 1302 Pulaski

WHITE LINES, WHICH CONTAIN NO INFORMATION, SHOULD BE LEFT BLANK. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCU- CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Alcoholism

Spec.—1-10-21—M&T—1500 Bks.

D77148

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77148

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 801 Scott ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F Koehnlein - Kaline

(a) RESIDENCE NO. 801 Scott ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie C Koehnlein

6 DATE OF BIRTH (month, day, and year): June 29 1862

7 AGE: Years 61 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: B & O. RR

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: George F Koehnlein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Mary C. Schalkause

(Address) 801 Scott st

15 Filed . . . . , 19 . . . . Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29 1923

17 I HEREBY CERTIFY, That I attended deceased from [illegible], 19[illegible], to [illegible], 19[illegible], that I last saw h[illegible] alive on [illegible], 19[illegible], and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

[illegible]

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

. 19 (Address) 1215 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Modern Cemetery — DATE OF BURIAL: July 2 1923

20 UNDERTAKER: J. E. Deems Light & Montgomery sts — ADDRESS

MAY 31 1923

MAY 31 1923

MAY 31 1923

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

Spec.—1-10-21—M&T—1500 Bks.

D77149

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77149

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2650 Edmondson Av. ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Nicon Neugand

(a) RESIDENCE NO. 2650 Edmondson Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Neugand

6 DATE OF BIRTH (month, day, and year) Mch 26 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paper Box Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Aug Schumann

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Geo Neugand

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Louis M Neugand
(Address) 2650 Edmondson Av

15 Filed JUN 30 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1923

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1923, to June 28, 1923, that I last saw h[illegible] alive on June 27, 1923, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) yrs. mos 7 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. E. Jones, M. D.

6/28, 1923 (Address) 720 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	June 30 1923

20 UNDERTAKER Geo J Jackson & Son

ADDRESS Norman Av

AGE should be stated EXACTLY. PHYSICIAN should state mation should be carefully supplied. so that it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that TION is very important. See Instructions on back of certificates.

D77150

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77150

CERTIFICATE OF DEATH.

674-00

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam Fischer

(Residence in Baltimore: No. 3129 O'Donnell St.; 30 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH, June 26 1868
(Month) (Day) (Year)

7-AGE. 55 yrs. — mos. 7 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Caspar Fischer

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Catherine Koch

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mon. Hess

(Address) 3718 Fait ave

15- Robert P. Harrison,

Filed JUN 30 1923 192.... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 28 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton M. D.
(Coroner)

June 29 1923. (Address) Curtis Bay, Balto. Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Sacred Heart Cem. DATE OF BURIAL. July 2 1923.

20-UNDERTAKER. Filby and Feiler. ADDRESS 403 S Mt St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77151

CERTIFICATE OF DEATH.

31 D77151

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 Beaumont Ave WARD) 27

2-FULL NAME Thomas P. Geren

(a) RESIDENCE No. 509 Beaumont Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 22-1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk Grocery Store

(b) General nature of industry, business, or establishment in which employed (or employer) Corner Beaumont & Ave

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Mathew Geren

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Sypes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary A Geren

(Address) 509 Beaumont Ave

15 Filed JUN 30 1923 . 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1923

17 I HEREBY CERTIFY, That I attended deceased from June 27 . 1923 . to June 29 . 1923 . that I last saw him alive on June 29 . 1923 . and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Tuberculosis of Testicle

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb-1918

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. Gill Hall, M. D.

June 29 1923 (Address) 1617 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL July 2 1923

20 UNDERTAKER H. C. Wadefield — ADDRESS 914 Gruman Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Dr. H. E. Knapp

HEALTH DEPARTMENT — CITY OF BALTIMORE

Assistant Registrar

D77152

CERTIFICATE OF DEATH.

D77152

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1928 Lemmon ST. 20 WARD)

2-FULL NAME Mary A. Allen

(a) RESIDENCE NO. 1928 Lemmon ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 4 mos. 27 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Peter R. Allen

6 DATE OF BIRTH (month, day, and year): Feb 2 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Henry Fitzenberger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary A. Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Peter R. Allen

(Address) 1928 Lemmon St

15 Filed JUN 30 1923, 19

Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 3, 1920, to June 29, 1923, that I last saw h[illegible] alive on June 29, 1923, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) about 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Paemisfluid (Cerebral Lumbago) (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) H. E. Knapp, M. D.

6/27, 1923 (Address) 1002 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: July 2 1923

20 UNDERTAKER: F. B. Hufford — ADDRESS: 2236 Eutaw Ave

---

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77153

CERTIFICATE OF DEATH.

139 D77153

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. St Joseph's Hospital ST., 1 WARD)

2-FULL NAME Lottie Owens.

(a) RESIDENCE NO. 06 S. Madeira ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Edward Owens

6 DATE OF BIRTH (month, day, and year) unk. 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mrs Gray

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Walter Green

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Katie Howard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Geo Green
(Address) 1118 Cumberland St

15 Filed ....., 19.... Robert P. Harrison, Registrar

N 30 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1 f, 1923, to June 28, 1923, that I last saw her alive on June 27, 1923, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Uterine Fibroid

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of June 26, 1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Geo L. Wesley, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury — DATE OF BURIAL July 1 1923

20 UNDERTAKER John W Henderson — ADDRESS 1502 E Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Time extended to July 1/23
J. Frederick Tompkins 2-3
Vital Statistics Comm.

D77154

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

71-00

D77154

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 122 S Carrollton Ave 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rita Bridgeon

(a) RESIDENCE. No. 122 S Carrollton Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 17 mos. 11 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 17th 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER George F Bridgeon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland U.S.

12 MAIDEN NAME OF MOTHER Margaret M. Knott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland U.S.

14 Informant (Address) Margaret M. Bridgeon 122 S Carrollton Ave

15 Filed JUN 30 1923 19 Registrar Robert P. Harrison,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1923

17 I HEREBY CERTIFY, That I attended deceased from June 21st, 1923, to June 29th, 1923, that I last saw h[illegible] alive on June 26, 1923 and that death occurred, on the date stated above, at 9.50 P m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis followed by Cerebro-Spinal Meningitis

(duration) yrs. one mos. 9 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur William M. D.

, 19 (Address) Elk Ridge Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	July 2 1923
20 UNDERTAKER	ADDRESS
John Steldo	1200 W Fayette St

AGE should be stated EXACTLY. PHYSICIAN'S should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77155 D77155

C-unknown

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH U. S. Veterans' Hosp. #56, Ft. McHenry, Md.

CITY OF BALTIMORE: (NO. ..... ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME LYNBURY, Isiah Edgar

(a) RESIDENCE NO. 402 Orchard St., Baltimore, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~mos.~~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
-	74	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) ---

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Hospital Records (Address) Ft. McHenry, Md. Harrison,

15 Filed ..... , 19 ..... Burial Permit Clerk Registrar

JUN 30 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1923, to June 28, 1923, that I last saw him alive on June 28, 1923, and that death occurred, on the date stated above, at 2:40 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cardio renal insufficiency

(duration) 2 yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) H. W. Barker, Surgeon (R), M. D.

6-29-23 (Address) U.S.Vets.Hosp.#56 Ft.McHenry,Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Chapel Cemetery Md	6/30 1923
UNDERTAKER W. S. Adolphus & Bro	ADDRESS 1127 E Balto St

AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONTRIBUTORY is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rls.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77156 101-001 D77156

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4002 Ridgewood Ave ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Kastner

(a) RESIDENCE NO. 4002 Ridgewood Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Kastner

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 63; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Travling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs A Kastner

(Address): 4002 Ridgewood Ave

15 Filed JUN 30 1923, 19 ... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 28 1923

17

I HEREBY CERTIFY, That I attended deceased from June 26/23 19 , to June 28 1923.

that I last saw him alive on June 28 1923,

and that death occurred, on the date stated above, at 1 P. m.

*CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R. C. Wetzel M. D.

June 29 1923 (Address) 1903 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship — DATE OF BURIAL: July 1st 1923

20 UNDERTAKER: Dan Sondheim — ADDRESS: 1117 W Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77157

CERTIFICATE OF DEATH.

101-001 D77157

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elijah Searles

(a) RESIDENCE NO. 1609 Latrobe St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None.

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25 years.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lumber City Georgia

PARENTS

10 NAME OF FATHER James Searles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Annie Elam

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Annie Searles

(Address) 1609 Latrobe St

15 Filed ..... 19 .....

Robert P. Harrison, Registrar

Burial Permit Clerk.

JUN 30 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1923

17

I HEREBY CERTIFY, That I attended deceased from June 22, 1923, to June 28, 1923, that I last saw him alive on June 28, 1923, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) General Weakness

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Gud Hall, M. D.

, 19 (Address) 426 E. 23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery

DATE OF BURIAL June 30 1923

20 UNDERTAKER Mrs. R. A. Elliott

ADDRESS 1727 Carlton

I. IMPORTANT. WRITE PLAINLY. PHYSICIANS should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77158

CERTIFICATE OF DEATH.

90 D77158

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 6 Traynor Rd. Hamilton (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia M. Kaufmann

(a) RESIDENCE NO. 6 Traynor Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced (or) WIFE of Louis A. Kaufmann

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Adelbrecht

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Sophia Kelly
(Address) 6 Traynor Rd

15 Filed JUN 30 1923, 19

Registrar

Robert P. Morrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26th 1923

17

I HEREBY CERTIFY, That I attended deceased from May 26 1923 to June 26 1923

that I last saw h alive on June 26 1923

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Senile Hypostatic Pneumonia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical

(Signed) Edward Zinsmeister M. D.

6-29 19 23 (Address) 1 E Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 7-2 19 23

20 UNDERTAKER J. A. Fahrenkamp

ADDRESS 1318 Light St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77159

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109-002 D77159

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hosp. 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Gordon Riehl

(a) RESIDENCE NO. Nursery & Childs Hosp ST., Franklin & Schroeder WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 9. 1921

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or min.
	2	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Milton R. Riehl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Alberta Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Milton R. Riehl

(Address) 911 S Paca St

15 Filed JUN 30 1923, 19.....

Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1923

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1923, to June 29, 1923, that I last saw him alive on June 29, 1923, and that death occurred, on the date stated above, at 7.45 a m.

The CAUSE OF DEATH* was as follows:

Vincents Angina

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Diphtheria Carrier

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscope

(Signed) Myron G Tull, M. D.

, 19 (Address) Sydenham

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lauden Park Cem	June 30 1923
20 UNDERTAKER	**ADDRESS**
A Howard Evans	1428 Charles St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write plainly. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77160

CERTIFICATE OF DEATH.

129 D77160

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1214 (St.) Pennsylvania Ave (Ward) 47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Jackson.

(a) RESIDENCE. (Usual place of abode) No. 1214 St. Pennsylvania Ave Ward.

Length of residence in city or town where death occurred 40 yrs. 7 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 12. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Day Cook.

9 BIRTHPLACE (city or town) Lancaster Co Va.
(State or country)

PARENTS

10 NAME OF FATHER Alfred Jackson

11 BIRTHPLACE OF FATHER (city or town) Lancaster Co Va
(State or country)

12 MAIDEN NAME OF MOTHER Prueda Day

13 BIRTHPLACE OF MOTHER (city or town) Lancaster Co Va
(State or country)

14 Informant Annie Jackson

(Address) 1214 Pennsylvania ave

JUN 30 1923

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1923

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1923, to June 28, 1923, that I last saw h er alive on June 27, 1923, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Chronic (duration) yrs. 2 mos. ? ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - (duration) yrs. 2 mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary - Dyspnea -

(Signed) Wilbur F Wright M. D.

(Address) 170 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
N.Y. Auburn Cem.	6/30 1923
20 UNDERTAKER Samuel T Hemsley	ADDRESS 578 N Bond St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77161

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 129 D77161

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

2-FULL NAME Eliza Elizabeth Smith

(a) RESIDENCE NO. Sykesville, Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Black	Married.

5a If married, widowed, or divorced (or) WIFE of George Smith.

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) Connellsville (State or country) Pa.

PARENTS

10 NAME OF FATHER Ned Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Holland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hospital Records (Address)

15 JUL 1 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1923

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1923, to June 30, 1923.

That I last saw her alive on June 30, 1923

and that death occurred, on the date stated above, at 12.50 P. m.

The CAUSE OF DEATH* was as follows:

Pelvic Abscess -

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis albuminuria

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ? -

Did an operation precede death? no Date of -

Was there an autopsy? no -

What test confirmed diagnosis? Clinical course -

(Signed) Anthony V. Buchman, M. D.

, 19 (Address) University Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Connellsville Md	July 3 1923
20 UNDERTAKER	ADDRESS
J. R. Neal	Sykesville

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77162

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 D77162

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob M. Ebberts

(a) RESIDENCE No. Bay View Hospital. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N.B.—WHITE PEARL, WHITE ONAPAQUE, PINK, BLUE, BUFF, GRAY and GREEN CARDS should be used for certificates. WRITE PLAINLY, with UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick, Md.

PARENTS

10 NAME OF FATHER William Ebberts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick, Md.

12 MAIDEN NAME OF MOTHER Annie Creamer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Municipal Hospital Records. (Address)

15 JUL 1 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 19 23

17

I HEREBY CERTIFY, That I attended deceased from March 16, 1923, to June 30 19 23

that I last saw him alive on June 29, 19 23

and that death occurred, on the date stated above, at 8:10 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of bowel

just weeks

Intervening (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Toxaemia from Carcinoma (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? not known.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathologic and clinical

(Signed) A.M. Shipley (M.D.), M. D.

6-30 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL 7/3 1923

20 UNDERTAKER Wm Cook ADDRESS 501 E Nor

Cor.—1-12-23—M&T—100 Bks.

D77163

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77163

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1809 Moreland Ave ST., 15 WARD)

2-FULL NAME ~~Samuel~~ Samuel F. Cooper

(a) RESIDENCE NO 1809 Moreland Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Cooper

6 DATE OF BIRTH (month, day, and year) about 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) Grocer
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Israel L. Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs E. Cooper
(Address) 1809 Moreland Ave

15 Filed JUL 1 1923, 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D.
(Coroner.)

June 29, 1923 (Address) 2502 Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Herrman Boundary	7/1/23 192

20 UNDERTAKER ADDRESS
Jack Levi's 1439 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks. D-77164

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77164

CERTIFICATE OF DEATH.

129 D77164

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 St Johns Road WARD 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Alice Dix

(a) RESIDENCE NO. 8 St Johns Road ST., WARD

(Usual place of abode) Retired

Length of residence in city or town where death occurred 10 yrs. 8 mos. 12 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

Baltimore City 56

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Octo 17 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Franklin Dix

11 BIRTHPLACE OF FATHER (city or town) Brownington
(State or country) Vermont

12 MAIDEN NAME OF MOTHER Rebecca Thomas Jenkins

13 BIRTHPLACE OF MOTHER (city or town) Bridgeburg
(State or country) Pennsylvania

14 Informant William A Dix
(Address) 203 Ash Road

15 JUL 1 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1923, to June 29th, 1923, that I last saw him alive on June 29th, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
Chronic Interstitial Nephritis
Hypocardiac Chronic
Unrest (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypocardiac Insufficiency
(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Lacy B Hamilton Jr., M. D.

June 30, 1923 (Address) 34 W Mt Royal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	July 2 1923
20 UNDERTAKER	ADDRESS
John B. Spence	1325 N. Caroline St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77165 D77165

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1433 E. Eager ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Davis

(a) RESIDENCE NO. 1433 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas Henry

6 DATE OF BIRTH (month, day, and year): March 5 1856

7 AGE: Years 67 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Joseph Bodrle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Switzerland

12 MAIDEN NAME OF MOTHER: Agnes Flemming

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Switzerland

14 Informant: William A Davis

(Address) 1433 E Eager St

15 Filed JUL 1 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 1923

17 I HEREBY CERTIFY, That I attended deceased from 4-21, 1923 to 6-30, 1923 that I last saw h alive on 6-30, 1923 and that death occurred, on the date stated above, at 6 30 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Auto Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) Fred Rumple M. D.

19 (Address) 600 N Bell Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebron — DATE OF BURIAL: July. 3 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Rks.

D77166

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77166

CERTIFICATE OF DEATH.

7H-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3200 N. Calvert ST. 17 WARD)

2-FULL NAME Esther Miller

(a) RESIDENCE. NO. 3209 N. Calvert ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Benjamin Miller

6 DATE OF BIRTH (month, day, and year): July 1st 1844

7 AGE — Years: 78 Months: 11 Days: 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Samuel Benjamin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Jane Buckle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Benjamin Miller 3209 N. Calvert St

15 Filed JUL 1 - 1923 ROBERT R. KRANTZ Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 1923

17 I HEREBY CERTIFY, That I attended deceased from June 23 1923 to June 30 1923 that I last saw her alive on June 29 1923 and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. L. Richard M. D.

6-30-1923 (Address) 3100 Allendale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dallas Cemetery — DATE OF BURIAL: July 3 1923

20 UNDERTAKER: Williams Cook — ADDRESS: 1502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77167

CERTIFICATE OF DEATH.

100-001 D77167

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 119 W. McComas St., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Virginia Scott

(a) RESIDENCE NO. 119 W. McComas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced (or) WIFE of HUSBAND of

6 DATE OF BIRTH (month, day, and year) May 31, 1916

7 AGE Years 7 Months 1 Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Cola R. Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mechanicsville Co. Va.

12 MAIDEN NAME OF MOTHER Virginia Lipscomb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Cola R. Scott

(Address) 119 W McComas

15 JUL 1 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1923

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1923, to June 29, 1923, that I last saw her alive on June 29, 1923, and that death occurred, on the date stated above, at 1.10 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward Williams, M. D.

(Address) 1200 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL July 4 1923

20 UNDERTAKER Wm. Cook ADDRESS 507 E. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77168 — 31 D77168

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 705 N. Collington ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Harley

(a) RESIDENCE. No. 705 N Collington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Christina Harley

6 DATE OF BIRTH (month, day, and year) Oct 10 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerical work

(b) General nature of industry, business, or establishment (in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Harley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Emma Porpirt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Christina Harley
(Address) 703 N. Collington ave

15 JUL 1 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1923

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1923 to June 28, 1923

that I last saw him alive on June 28, 1923.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter G. Keene M. D.

(Address) 1716 Jefferson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: July 2 1923

20 UNDERTAKER: Frank Brockton — ADDRESS: 1906 Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77169 (PLACE OF DEATH)

CERTIFICATE OF DEATH

90 D77169 (REGISTERED No. C)

CITY OF BALTIMORE (No. 207 Woodlawn Rd | ST. | WARD) (If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Annie Thomas (Col)

(Residence in Baltimore: No. 233 Dolphin St; St.: 35 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: (Month) (Day), 1853 (Year)

7 AGE: 70 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: George Thomas

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Mason

13 BIRTHPLACE OF MOTHER (State or country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elenora Barber

(Address) 233 Dolphin St.

JUL 1 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June 30th (Month) (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 30th, 1923, to June 30th 1923, that I saw her alive on June 30th, 1923, and that death occurred, on the date stated above, at 4 A. m.
The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

20 min

(Duration) yrs. mos. ds.

Contributory (SECONDARY) Senility - Arterio sclerosis - Chronic Endo myocarditis ?

(Duration) ? yrs. mos. ds.

(Signed) Ogdenham R. Clarke M. D.

June 30th, 1923 (Address) 1 St. Johns Rd - Roland Pa

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

	yrs.	mos.	ds.		yrs.	mos.	ds.
At place of death				In the State			
Where was disease contracted, if not at place of death?							
Former or usual residence							

19 PLACE OF BURIAL OR REMOVAL: Mechanicsville Md — DATE OF BURIAL: 7-2-1923

20 UNDERTAKER: Lemuel Easton — ADDRESS: 916 Pa ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D77170

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77170

CERTIFICATE OF DEATH.

188-003

REGISTERED No. C

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 619 N. Fremont Ave ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milbur Washington

(Residence in Baltimore: No. 1030 Wilmot alley St.: 9 yrs., 11 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	single

6-DATE OF BIRTH, July (Month) 6 (Day), 1914 (Year)

7-AGE, 9 yrs. 11 mos. 20 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Thos. Washington

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mary E. Moore

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. Washington

(Address) 1030 Wilmot alley.

15- Filed JUL 1 - 1923, 19.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 28 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull
automobile accident
accidental (Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... instant death
(Duration) ... yrs. ... mos. ... ds.

(Signed) J. J. Kennedy M. D. (Coroner.)

June 29. 1923. (Address) 2802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	July 2, 19 23.
20-UNDERTAKER	ADDRESS
Chas Easton	916 Pa ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

KODAK

Spec.—8-24-14—M. & T.—2000 Bks.

D77171

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77171

CERTIFICATE OF DEATH.

21

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE: (No. Pimlico Road near Hayward Av St. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL Minnie Katherine Jones

(Residence in Baltimore: No. Pimlico Road St.; 1 yrs., 2 mos. 6 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED.~~ (Write the word.)

6-DATE OF BIRTH, April 24, 1922 (Month) (Day) (Year)

7-AGE, 1 yrs. 2 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Stanley Jones

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Minnie Jones

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Stanley Jones

(Address) Pimlico Road

15- Filed JUL 1 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 30, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 21 1923, to June 30 1923, that I saw her alive on June 30 — 1923, and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Pneumonia Broncho

(Duration).....yrs.....mos. 4 ds.

CONTRIBUTORY (Secondary) Empyema

(Duration).....yrs.....mos. 6 ds.

(Signed) Charles Jopkins M. D.

June 30, 1923 (Address) 1101 St Paul

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Mary's Hampden — DATE OF BURIAL, July 2, 1923

20-UNDERTAKER Chenoweth Son — ADDRESS Chestnut

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77172

CERTIFICATE OF DEATH.

90 D77172

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3418 Harford ave ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine L. Erdman

(a) RESIDENCE. NO. 3418 Harford ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 23 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Gottlieb H Erdman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Dorothy Lamley

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Co Md

14 Informant Eleanor Lamley
(Address) 3418 Harford ave

Filed JUL 1 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1923

17 I HEREBY CERTIFY, That I attended deceased from June 18th 1923, to June 30th 1923, that I last saw h[illegible] alive on June 29th 1923, and that death occurred, on the date stated above, at 8.15 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease
(Mitral Stenosis)

(duration) yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. S. Kirk M. D.

6/30 1923 (Address) 3126 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	July 3rd 1923
20 UNDERTAKER George L Schilling & Sons	ADDRESS 1126 Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77173

CERTIFICATE OF DEATH.

129 D77173

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 922 E. Madison ST.: 10 WARD)

2-FULL NAME Joseph T. Holmes

(a) RESIDENCE. NO. 922 E. Madison St. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Betty Holmes

6 DATE OF BIRTH (month, day and year) May 2 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or mln.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General. 040

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Caroline Co. Va.

PARENTS

10 NAME OF FATHER Thomas Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Caroline Co. Va.

12 MAIDEN NAME OF MOTHER Mary Payne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Caroline Co. Va.

14 Informant John W. Holmes (Address) 918 Lorraine Ave Baltimore

15 FILED JUL 1 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 29 June 1923

17 I HEREBY CERTIFY, That I attended deceased from 19/6/23 to 29/6/23 that I last saw h[illegible] alive on 28/6/23 and that death occurred, on the date stated above, at 2.9. m.

The CAUSE OF DEATH* was as follows:

Nephritis

unknown

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia.

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Chemical

(Signed) Mayfield Payne, M. D.

(Address) 425 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Grove Cemetery	July 1 1923

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 1716 Eastlandon

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77174 ✓ X 47 D77174

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Christ Institution Hospital

CITY OF BALTIMORE: (No. 704 Ensor ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Branson

(a) RESIDENCE No. 16 Shipley Ave Catonsville Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James. Branson

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
30	years	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Howard County

PARENTS

10 NAME OF FATHER: Henry Law

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Garfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Christ Institution Hosp. (Address) 704 Ensor Street

15 Filed JUL 1 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1922. to June 29. 1923.

that I last saw her alive on June 29. 1923.

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

Carcinoma of Breast (duration) yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary) + Gangrene (duration) 1 yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? Catonsville Md.

Did an operation precede death? yes Date of June 3-1922

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. L. Wehrmann M. D.

(Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Odd Fellows Cemy	July 1 1923
20 UNDERTAKER	ADDRESS
Mrs. R. A. Elliott	1725 Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77175

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77175

CERTIFICATE OF DEATH.

44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No. 176 N. Broadway ST., 76 WARD)

2-FULL NAME Mrs. John E. O'Connor

(a) RESIDENCE NO. 3224 Eastern Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia A O'Connor

6 DATE OF BIRTH (month, day, and year) Mar 25th 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel Prop.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Hugh O'Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ann Penny

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant V. O'Connor. (Address) 3224 Eastern Ave.

15 Filed JUL 1 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1923

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1923, to June 28, 1923, that I last saw h[illegible] alive on June 28, 1923 and that death occurred, on the date stated above, at 10 45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Sclerosis & Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 28 1923

Was there an autopsy? No

What test confirmed diagnosis? X Ray, Clinical, Operation

(Signed) Richard G. Coblentz, M. D.

, 19 (Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 7/2 1923

20 UNDERTAKER John A. Moran — ADDRESS 3000 E Baltimore St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77176

CERTIFICATE OF DEATH. 188-001 D77176

Registered No. C.....

1-PLACE OF DEATH Pronounced dead at

City of BALTIMORE: (No. St. Joseph Hospital St., 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Kimmelman

(Residence in Baltimore: No. 10th and Eager Sts. (Orangeville) St.; yrs. 70 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced (Write the word.)
female	white	married

6-DATE OF BIRTH, ~~June 28 1853~~ Dec 8th 1852
(Month) (Day) (Year)

7-AGE, 70 yrs. 6 mos. 23 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Germ any

PARENTS.

10-NAME OF FATHER: Jos. Kaufman

11-BIRTHPLACE OF FATHER, (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Thersa Huber

13-BIRTHPLACE OF MOTHER, (State or Country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John J. ROdman

(Address) 10th and Eager Sts.

15-
FILED JUL 1 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 27 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said her inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accidental struck by railroad train Band O R.R. Train No. 524 nr. 12th St. (Orangeville(

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. S. H. Vale M. D.
(Coroner.)

508e " 1923 (Address) 508nE. North Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Oak Lawn Cemetery DATE OF BURIAL: July 2 1923

20-UNDERTAKER: Geo M Zinkan ADDRESS 811 N Wolfe St

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

77 D 77177

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X90 D 77177

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Grand Senator St., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry J. Fryzinger

(a) RESIDENCE NO. Penn Mar Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Mary Fryzinger

6 DATE OF BIRTH (month, day, and year) May 7 186X

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	1	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ill.

PARENTS

10 NAME OF FATHER Jacob Fryzinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ill

12 MAIDEN NAME OF MOTHER Mc Knon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md Knon

14 Informant Mrs Mary Fryzinger
(Address) Penn Mar Pa.

15 Filed JUL 2 1923 G. H. Greff Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart disease

(duration) yrs. 2 mos. ds.

(Signed) W. H. Forsch, M. D. (Coroner)

6-30-1923 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July 2 1923

20 UNDERTAKER W M Rountree ADDRESS 2258 N Fulton Ave

Spec.—1-10-21—M&T—1500 Bks.

77178 D77178

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 D77178

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 150 N Caroline ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph C. Creamer

(a) RESIDENCE NO. 150 N Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cath Creamer

6 DATE OF BIRTH (month, day, and year): 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Jos Creamer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Lydia Annette

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Mary Creamer

(Address): Brooklyn

15 JUL 2 - 1923 C. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 16, 1923, to June 28, 1923, that I last saw h alive on June 27, 1923, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Ashenbach R., M. D.

1923 (Address) 1412 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill

DATE OF BURIAL: 7/2 1923

UNDERTAKER: J. Lakey Wood

ADDRESS: 131 S Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77179

CERTIFICATE OF DEATH.

Roland Pk

74-D77179

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Evandale Road ST.: ... WARD) 27

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Cole

(Residence in Baltimore: No. Evandale Road St.; 40 yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) Single

6-DATE OF BIRTH, Dec 24, 1858 (Month) (Day) (Year)

7-AGE, 64 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Hammerer
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9-BIRTHPLACE, (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER, James Leonard.

11-BIRTHPLACE OF FATHER (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER Mary A O'Brien

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas F. Cole

(Address) Evandale Ave

15- Roland Park

Filed ..., 191... JUL 2 - 1923 G. H. Grese Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 28, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 27 1923, to June 28 1923, that I saw h[illegible] alive on June 28 1923, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(Duration) 1 yrs. 2 mos. ... ds.

(Signed) M. D. Porter M. D.

June 29, 1923 (Address) 427 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral Cemetery	July 2, 1923
20-UNDERTAKER	ADDRESS
Geo. F. Rieth	1730 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77180

CERTIFICATE OF DEATH.

90 D77180

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1415 E Lanvale St.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Carrie O'Connor

(a) RESIDENCE. NO. 1415 E Lanvale ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 28, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	Years.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Joseph O Connor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Dempsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Joseph O Connor
(Address) 1415 E Lanvale St

15 Filed JUL 2 - 1923 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1 - 1923, to June 28, 1923.

that I last saw h[illegible] alive on June 28, 1923.

and that death occurred, on the date stated above, at 6.30 p m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broken Compensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Consulting Dr

(Signed) J S Clinton Blades, M. D.

6/30/23 19 (Address) 1436 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	July 2 1923

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D 164579. 10 25 P.M. D 77181

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D 77181

CERTIFICATE OF DEATH. 60-001

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 13 WARD)

2-FULL NAME Mrs. Lizzie Custus.

(a) RESIDENCE No. 2316 McCulloh St ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. imporun mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored.	Married.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Frankie Custus.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	39.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife.

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Robert Parks Custus.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Minnie Johnston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUL 2. 1923 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 21 1923. to June 27 1923.

that I last saw her alive on June 27 1923.

and that death occurred, on the date stated above, at 10 25 P. m.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exophalmic goitre

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 25

Was there an autopsy? Yes

What test confirmed diagnosis? — Path. Apecimen

(Signed) Warfield M Firor, M. D.

6/28 1923 (Address) J H Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL July 2nd 1923

20 UNDERTAKER Joseph A Farrell

ADDRESS 1319 Druid...

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

mation should be carefully supplied.

Spec.—1-10-21—M&T—1500 Bks.

D77182

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77182

X 100-002

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1421 Riggs Ave ST. WARD)

2-FULL NAME Mary Margaret Queen.

(a) RESIDENCE NO. 1421 Riggs Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer At Large

9 BIRTHPLACE (city or town) (State or country) Sun Prairie Dane county Wis

PARENTS

10 NAME OF FATHER Augustus Queen

11 BIRTHPLACE OF FATHER (city or town) " (State or country) "

12 MAIDEN NAME OF MOTHER Ortray Clark

13 BIRTHPLACE OF MOTHER (city or town) " (State or country) "

14 Informant Laura Harris (Address) 1530 N Fremont St

15 Filed JUL 2 - 1923, 19 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1923

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1923, to June 29, 1923, that I last saw h-r alive on June 28, 1923 and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows:

Capilliary Bronchitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Partial paresis.

(duration) yrs. mos. 20 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Bernard J. Francis M. D.

(Address) 707 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL July 3rd 1923

20 UNDERTAKER Joseph A Farrell

ADDRESS 2319 Eastern Ave

...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77183

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77183

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1509 Mosher. ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha L. C. White

(a) RESIDENCE. No. 1009 Mosher ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1821

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
52	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Edward Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Martha L. C. Banks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Florence White (Address) 1509 Mosher St

15 JUL 2 - 1923 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 29 - 1923

17 I HEREBY CERTIFY, That I attended deceased from June 22nd, 1923, to June 29th, 1923, that I last saw h[illegible] alive on June 28, 1923, and that death occurred, on the date stated above, at 6:10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Hemorrhages, (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jas A Cooper, M. D.

, 19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: July 2 1923

20 UNDERTAKER: John H. Toadvine — ADDRESS 142 Uttie

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77184 D77184

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 752 W. Redwood ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Moore

(a) RESIDENCE NO. 752 W. Redwood ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Moore

6 DATE OF BIRTH (month, day, and year): July 4 1860

7 AGE: Years 52 Months 11 Days 25 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer: do

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Marion Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Adeline Moore (Address) 765 W. Saratoga

15 JUL 2 - 1923 J.L.K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/29/1923

17

I HEREBY CERTIFY, That I attended deceased from 6/19/1923, to 6/29/1923, that I last saw h alive on 6/28/1923, and that death occurred, on the date stated above, at 4:25 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Pulmonic Parenchymatous Nephritis (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. Guy Bowley M. D.

6/29, 1923 (Address) 908 N. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: July 2, 1923

UNDERTAKER: P. C. Gross — ADDRESS: 1405 McElderry

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Bks.

D77185

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77185

CERTIFICATE OF DEATH.

34

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 E Fort Ave ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Meade.

(a) RESIDENCE NO. 702 E Fort Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 9 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Wm M. Meade

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Bertha Hass. 6/30 1923

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Pearl A Sies (Address) 258 E Fort Ave

15 Filed JUL 2- 1923 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1923

17 I HEREBY CERTIFY, That I attended deceased from June 20. 1923. to June 30. 1923.

that I last saw he alive on June 29, 1923.

and that death occurred, on the date stated above, at 3 30 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Spine.

Do not know.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs.

(Signed) Sidney H. Street M. D.

(Address) 405 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Balto Cemetery

DATE OF BURIAL July 3 1923

20 UNDERTAKER John Ulrich

ADDRESS 2108 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77186

D77186

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Leek

(a) RESIDENCE NO. 228 N. Paca St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER William Leek

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Sophie Hamilton

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Mrs. Sophia Leek
(Address) North & Laccan

15 JUL 2 - 1923 L.L.K Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1923

17

I HEREBY CERTIFY, That I attended deceased from May 10, 1923, to July 1, 1923,

that I last saw her alive on July 1, 1923

and that death occurred, on the date stated above, at 8:36 P.m.

The CAUSE OF DEATH* was as follows:

Empyema

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? 228 N. Paca St.,

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John A. Schentich, M. D.

, 19 (Address) St. Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

St. Peters Cemet

DATE OF BURIAL July 4, 23

20 UNDERTAKER

Walker & Chaires, 1018 Edmond Ave

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Bronchio
Operation for Empyema
2 weeks ago

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77187

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77187

CERTIFICATE OF DEATH.

118-002

1-PLACE OF DEATH Hebrew Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Eisenstein

(a) RESIDENCE. NO. 1103 E. Lombard ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julius Eisenstein

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Levy 1439 E Baltimore

JUL 2 - 1923

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1923

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1923, to July 1, 1923, that I last saw h[illegible] alive on July 1, 1923, and that death occurred, on the date stated above, at 8:05 P.m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. 20 mos. days

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. 48 days

18 Where was disease contracted if not at place of death? At residence.

Did an operation precede death? yes Date of June 30

Was there an autopsy? yes

What test confirmed diagnosis? None

(Signed) Isidor Levy, M. D.

. 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Hebrew Southern Cem July 2 1923

20 UNDERTAKER — ADDRESS

Jack Levy 1439 E Baltimore

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77188

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77188

CERTIFICATE OF DEATH. X 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Reed

(a) RESIDENCE NO. Chrisfield, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or .. min.
62	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Bob White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Irene Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Municipal Hospital Records.

(Address) UNIVERSITY OF MARYLAND

JUL 2 - 1923 F.L.K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28, 1923

17

I HEREBY CERTIFY, That I attended deceased from June 27, 1923. to June 28, 1923.

that I last saw him alive on June 28, 1923

and that death occurred, on the date stated above, at 11:20 A.M.

The CAUSE OF DEATH* was as follows:

Septicemia following Multiple Varicose Ulcers L left leg.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) A. M. Shipley M. D.

6-29-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL JUN 30 1923 19

20 UNDERTAKER Commissioner Health,

ADDRESS

Per. Wm. S. WORSALL

MARRIED WOMEN, WIDOWED OR DIVORCED. EARLY information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77189 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77189

CERTIFICATE OF DEATH.

38

1—PLACE OF DEATH Bay View Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 12 WARD)

2—FULL NAME Albert Gieselman

(a) RESIDENCE NO. 2021 Maryland Ave. ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced, (write the word)~~: Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE — Years: 45 — Months: ..... — Days: ..... — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER: .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do.

14 Informant (Address): Bay View Hospital

15 Filed JUL 2 - 1923 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1923, to June 26, 1923, that I last saw him alive on June 26, 1923, and that death occurred, on the date stated above, at 2.45 a. m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) General Paralysis

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Evidence and Pathological Findings

(Signed) H. J. Gieselman M. D.

19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND. DATE OF BURIAL: JUN 30 1923, 19

20 UNDERTAKER: Commissioner Health, Per: WM. E. WOODALL ADDRESS .....

NOTE—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should indicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lactic Infection

Spec.—1-10-21—M&T—1500 Rks.

D77190 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77190

CERTIFICATE OF DEATH. 162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital - ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Cole

(a) RESIDENCE No. Relay - Md - ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or Divorced, ~~(write the word)~~
Male	White	

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) July 1-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) St. Agnes Hospital (State or country)

PARENTS

10 NAME OF FATHER Louis Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore - Md

12 MAIDEN NAME OF MOTHER Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Louis Cole. (Address) Relay Md

15 Filed JUL 2 - 1923, 19 G. H. Gresse Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1- 1923

17 I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19..., that I last saw h... alive on ....., 19..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Chest Cord Heart Pulmonary

pro Longer Cord Cord -

Ex Treme - Mouldning -

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Cord arrest Mal

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Frederick V. Bruce, M. D.

7-1-, 1923 (Address) Relay - Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	July 2 1923
20 UNDERTAKER	ADDRESS
E. A. Windsor Jr.	501 E 22 St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77191

CERTIFICATE OF DEATH.

91-002 D77191

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1900 Eastern ST., W WARD)

2-FULL NAME Mary Shutter.

(a) RESIDENCE NO. 1900 Eastern ST., 2 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Wm H Shutter

6 DATE OF BIRTH (month, day, and year) April 1837

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Benjamin Owings

11 BIRTHPLACE OF FATHER (city or town) U.S. (State or country)

12 MAIDEN NAME OF MOTHER Nancy Gibson

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Dr. Herman J. Giering

(Address) 1900 Eastern ave.

15 Filed JUL 2 - 1923 G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 26 1923 to June 29th 1923, that I last saw her alive on June 29th 1923, and that death occurred, on the date stated above, at 12 15 a. m.

The CAUSE OF DEATH* was as follows:

Senility.

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis + Heart Lesion (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? /

(Signed) J W Ader, M. D.

, 19 (Address) 118 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Eastern Cemetery	July 2nd 1923
20 UNDERTAKER	ADDRESS
Lilly Zeiler	4003 Wolfe

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77192

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77192

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2000 Fountain St., V Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theresa McCord

(Residence in Baltimore: No. 2000 Fountain St. St.; yrs., 48 mos., 15 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. June (Month) 15 (Day) 1875 (Year)

7-AGE. 48 yrs. — mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. John Reynolds

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm H. McCord

(Address) 2000 Fountain St

15-

Filed JUL 2 1923 1923

Registrar.

G. H. Grese

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 1st (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by me (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) ... yrs. ... mos. 2 hrs

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Thos B. Horton M. D.
Coroner

July 1st 192 3 (Address) Curtis Bay, Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Mount Carmel Cem. DATE OF BURIAL. July 5th 1923

20-UNDERTAKER, Lilly & Zeiler ADDRESS 403 S. Wolfe St.

U. S.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D77193

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77193

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1528 Holbrook St. ST., 9 WARD)

2-FULL NAME Annie. M. Bockstie

(a) RESIDENCE NO. 1528 Holbrook St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. — mos. — ds. How long in U. S., if of foreign birth? 41 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of August. W. Bockstie

6 DATE OF BIRTH (month, day, and year) June-4-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	----	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Hamman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mr. August. W. Bockstie

(Address) 1528 Holbrook St.

15 JUL 2 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June-30-1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to June 30, 1923

that I last saw him alive on June 30, 1923

and that death occurred, on the date stated above, at 6:05 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 2 mos. ds.

CONTRIBUTOR (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Rhyand Dunbarton, M. D.

7-1-1923 (Address) 1531 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetary — DATE OF BURIAL: July-6-1923

20 UNDERTAKER: Henry Hoech & Son — ADDRESS: 1301 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77194

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77194

117

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ~~1910 Bolton~~ ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Johnson

(a) RESIDENCE NO. 1910 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 0 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~ 4 COLOR OR RACE: White 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mamie Johnson

6 DATE OF BIRTH (month, day, and year): June 8 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63		23	

8 OCCUPATION OF DECEASED

(a) Trade, profesion or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm H. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Mary Abrahams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs. Mamie Johnson

(Address): 1910 Bolton St.

15 JUL 2 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-1 1923

17 I HEREBY CERTIFY, That I attended deceased from June 18 1923 to July 1 1923.

that I last saw him alive on July 1 1923.

and that death occurred, on the date stated above, at 9.55 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured appendix with localized peritonitis.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Toxic Myocarditis and general peritonitis (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6-18-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) R. J. Pleyler M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park DATE OF BURIAL: July 5 1923

20 UNDERTAKER: W. J. Tuckerman Sons ADDRESS: North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77195

CERTIFICATE OF DEATH. 100 - 001

D77195

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2108 Longwood St., 15 Ward)

2-FULL NAME Mary Elizabeth Frohwitter

(a) RESIDENCE NO. 2108 Longwood St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 3 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. S. Frohwitter

6 DATE OF BIRTH (month, day, and year): Mar. 29 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christ Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss Carrie A. Frohwitter

(Address) 2108 Longwood St

15 Filed DEC 2 - 1923 19.. L. L. K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 1923

17

I HEREBY CERTIFY, That I attended deceased from June 13th, 1923, to June 30th, 1923,

that I last saw her alive on June 30th, 1923,

and that death occurred, on the date stated above, at 3.15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isaac E. Dickson, M. D.

, 19 (Address) 3055 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. | DATE OF BURIAL: July 2, 23

20 UNDERTAKER: Wm. H. Pickerodt Sons | ADDRESS: Pontiac

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D77196

CERTIFICATE OF DEATH. 161-002 D77196

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital, 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Schneider

(a) RESIDENCE No. 1813 N. Calvert St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Infant

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years — Months — Days | If LESS than 1 day, 4 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: August Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Johanna Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant (Address): August Schneider 1818 N. Calvert

15 Filed JUL 2 - 1923, 19 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): July 1 1923

17

I HEREBY CERTIFY, That I attended deceased from July 1- 1923, to July 1- 1923.

that I last saw her alive on July 1- 1923.

and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:

Prolonged labor (R.O.P.).

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cranial hemorrhage (duration) yrs. mos. 4½ hrs ds. — High forceps

18 Where was disease contracted if not at place of death? 1813 N. Calvert.

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Dudley P. Bowe, M. D.

. 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MOUNT CARMEL CEM	JULY 2 1923
20 UNDERTAKER ROBERT BROOKS & SON	ADDRESS CALHOUN HOLLINS ST

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77197

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 188-003 D77197

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hospital St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Agnes Doherty PK

(Residence in Baltimore: No. 1032 N. Patterson Ave St.; yrs. 5/12 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	single

6-DATE OF BIRTH. Feb 21/1917 (Month) (Day) (Year)

7-AGE. 6 yrs. 4 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS:

10-NAME OF FATHER. Frank Doherty

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Lillian Eder

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Doherty PK

(Address) 1032 N. Patterso

15- JUL 2 - 1923 19.. J. L. K. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 30/23 (Month) (Day) (Year) 192..

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inqiiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck by Automobile- Fract. Skul

Inquest to be held July 2/23

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. H. Collins M. D. (Coroner.)

7/2/23 192.. (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. New Cathedral DATE OF BURIAL. July 3rd 1923.

20-UNDERTAKER. John A Moran ADDRESS 3000 E. Balto. St.

D77198 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 57 D77198

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella M. Poland

(Residence in Baltimore: No. 3304 O'Donnell St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	mar

6-DATE OF BIRTH. August 8/1889 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
33 yrs. 10 mos. 23 ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto Md.

PARENTS:

10-NAME OF FATHER. James C. Brown

11-BIRTHPLACE OF FATHER. (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Mary E. Kiefer

13-BIRTHPLACE OF MOTHER. (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Poland

(Address) 3304 O'Donnell

15- JUL 2 - 1923 ROBERT R. KRAUTER

19 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 1st. 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus died in coma

(Duration) 2 or 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Packer M. D. (Coroner.)

July 2 1923 (Address) Tpl 3, North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Parkwood DATE OF BURIAL. July 4 1923

20-UNDERTAKER. Pinkler & Pinkler ADDRESS 1739 Eager

Spec.—1-10-21—M&T—1500 Blks.

D77199

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D77199

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1716 N. Montford ave ST. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Loeffler

(a) RESIDENCE No. 1716 N. Montford ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Loeffler

6 DATE OF BIRTH (month, day, and year) June 30 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Loeffler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Vansant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Mrs Rose Loeffler

(Address) 1716 N Montford ave

15 JUL 2 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to June 30, 1923

that I last saw her alive on June 30, 1923

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum.

6 mos (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? yes Date of July 1923.

Was there an autopsy? no Microscope

What test confirmed diagnosis? —

(Signed) Emma C. Lellerich, M. D.

July 2 1923 (Address) 928 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: July 3 1923

20 UNDERTAKER: Henry Lutz — ADDRESS: 1203 N. Broadway

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

161-001 D77200 5302

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~STILLBIRTH~~ No. 13629

13629 D77200

CERTIFICATE OF DEATH

1-PLACE OF DEATH Maryland General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Davidson

(a) RESIDENCE No. 260 Fallendale Rd. ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 11 hrs ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White Jewish

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	-	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Barnett D. Davidson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chicago Illinois

12 MAIDEN NAME OF MOTHER Dorothy Zerwitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant B. D. Davidson
(Address) 260 Allendale Rd.

15 Filed JUL 7 - 1923 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1st 1923, to July 1st 1923, that I last saw her alive on July 1st 12:00 M 1923 and that death occurred, on the date stated above, at 3.45 P m. 8.30 AM

The CAUSE OF DEATH* was as follows:

Pneumonia.
(6 days)

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Adolescent

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) ... M. D.

, 19 (Address) ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem. DATE OF BURIAL: 7/2 1923

20 UNDERTAKER: Jack Levin ADDRESS: 439 Eutaw St

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See Instructions on

Spec.—1-10-21—M&T—1500 Blks.

D77201

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

159-002 D77201

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homewood Hospital WARD)

2-FULL NAME Baby Swann

(a) RESIDENCE NO. Homewood Hospital WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2 1923

7 AGE Years ... Months ... Days ... If LESS than 1 day hrs. or 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Homewood Hospital.

PARENTS

10 NAME OF FATHER Harold Irving Swann

11 BIRTHPLACE OF FATHER (city or town) Hoffmanville (State or country) Balto. Co. Md.

12 MAIDEN NAME OF MOTHER Margaret L. Butcher

13 BIRTHPLACE OF MOTHER (city or town) Warren (State or country) Balto. Co. Md.

14 Informant Mr. Harold Irving Swann (Address) 3370 Hickory Ave-City

15 Filed ..., 19... ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2d 1923

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1923, to July 2, 1923, that I last saw him alive on July 2, 1923, and that death occurred, on the date stated above, at 10-30 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

Foramen Ovale not Closed.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. L. Fair, M. D.

, 19 (Address) 12 E. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys, Hampden | DATE OF BURIAL: July 3 1923

20 UNDERTAKER: Chenoweth & Son | ADDRESS: Electric

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D77202

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D77202

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Mercy Hospital St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Morkin

(a) Residence No. 204 Hodcroad Hodges Highland Park St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) ? ? 1875

7-AGE.	If LESS than 1 day,
48 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS

10-NAME OF FATHER, Patrick Morkin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Welch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Miss Mamie Martin

(Address) 415 N Chapel St

15- Filed JUL 2 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 30 1923

17- I HEREBY CERTIFY, That I attended deceased from June 29 19 23 to June 30 19 23

that I last saw h alive on June 30 19 23

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy - Intracranial Hemorrhage

(Duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs

(Signed) H. J. Stander M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
Cathedral Cemetery	7/3, 19 23
20-UNDERTAKER.	ADDRESS
Henry W. Mears & Son	805 N. Calvert

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FEE TY K S·A P

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77203 ✓ D77203

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 137 N Caul ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma L Crouch

(a) RESIDENCE NO. 137 N Caul ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of James L Crouch

6 DATE OF BIRTH (month, day, and year) Mar 12 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Caroline Co Md

PARENTS

10 NAME OF FATHER Isaac Nottett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Porter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del

14 Informant James L Crouch

(Address) 137 N. Caul St

15 Filed JUL 2 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1923

17

I HEREBY CERTIFY That I attended deceased from June 20, 1923, to July 2, 1923,

that I last saw her alive on July 2, 1923

and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stafford Drain, M. D.

, 19 (Address) 1227 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Tolchester Md	July 3 1923

20 UNDERTAKER	ADDRESS
Robt Johnson Inc	1 N Bond

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77204

D77204

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3021 Baker St. ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry L Simons

(a) RESIDENCE. No. 3021 Baker St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White Hebrew	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 16, 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 166

(b) General nature of Industry, business, or establishment in which employed (or employer) The Gas & Electric Co

(c) Name of employer The Gas & Electric Co

9 BIRTHPLACE (city or town) New Haven
(State or country) Connecticut

PARENTS

10 NAME OF FATHER Simon Simons

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Conn.

12 MAIDEN NAME OF MOTHER Elizabeth Pfleuchheimer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Benj F Simons
(Address) 1601 Hilton St

15 Filed JUL 2 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1st 1923

17

I HEREBY CERTIFY, That I attended deceased from January 1st, 1923, to July 1st, 1923, that I last saw h[illegible] alive on July 1st, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Lung affection (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No Physician's Observation

What test confirmed diagnosis? Microscopic

(Signed) Emmett Finch, M. D.

. 19 (Address) 2937 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
New York City	July 4 1923

20 UNDERTAKER W M Rankin

ADDRESS 2238 N Howard

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77205

CERTIFICATE OF DEATH.

113 D77205

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 773 W Mulberry ST., 4 WARD)

2-FULL NAME Bernard Heil

(a) RESIDENCE No. 773 W Mulberry st ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 20 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		3	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Bath city
(State or country) O

PARENTS

10 NAME OF FATHER H Heil

11 BIRTHPLACE OF FATHER (city or town) md
(State or country)

12 MAIDEN NAME OF MOTHER Katie Berger

13 BIRTHPLACE OF MOTHER (city or town) md
(State or country)

14 Informant Otto Heil
(Address) 773 W Mulberry St

15 Filed JUL 2 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 2 July 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Coroner or Inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Wood & Heal

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W A Jones M. D.
(Coroner.)

7-2, 1923 (Address) 111 W Saratoga st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 3 1923
20 UNDERTAKER John M. Johnson	ADDRESS 1304 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77206

CERTIFICATE OF DEATH.

129 D77206

REGISTERED NO.

1-PLACE OF DEATH 3019 Garrison Av Balto

CITY OF BALTIMORE: (No. 189 W Mulberry ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Linton Merryman

(a) RESIDENCE No. 3019 Garrison Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 15. 1859

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
63	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bond Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Samuel HB Merryman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Martha Clunet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Susan L Clarke Sister (Address) 3019 Garrison Blvd

15 JUL 2 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 3, 1923, to July 1, 1923

that I last saw him alive on June 30, 1923

and that death occurred, on the date stated above, at 7 20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis.

Cat concurrent with Chronic Interstitial nephritis

Indefinite (duration) yrs mos ds.

CONTRIBUTORY (Secondary) Indefinite (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Nephritis by chemist and micro — scopical analysis

(Signed) H. H. Arthur M. D.

July 2, 1923 (Address) 1426 Wendover Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem.	July 3. 23
20 UNDERTAKER	ADDRESS
Wm Hickner & Sons	Hotel Kp 2

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77207 — 46 — D77207

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 Cedar Avenue ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Bortner

(a) RESIDENCE No. 119 Cedar Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel M. Bortner

6 DATE OF BIRTH (month, day, and year) July 5, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

837

9 BIRTHPLACE (city or town) (State or country) Penn.

PARENTS

10 NAME OF FATHER John Bensel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Daniel M. Bortner (Address) 119 Cedar Avenue.

15 Filed JUL 2 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/1 1923

17

I HEREBY CERTIFY, That I attended deceased from June 28, 1923, to 7/1, 1923, that I last saw h[illegible] alive on 7/1, 1923, and that death occurred, on the date stated above, at 3P m.

The CAUSE OF DEATH* was as follows: Coronary Thrombosis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry T. Coe, M. D.

(Address) 1 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	July 4, 1923
20 UNDERTAKER	**ADDRESS**
E. LeRoy Stifflen	1255 North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77208 HEALTH DEPARTMENT—CITY OF BALTIMORE. ✓ X 90 D77208

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Joseph's Hospital 9 REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Marie A. Burns

(a) RESIDENCE NO. ..... Wynne, Md. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt. H. Burns

6 DATE OF BIRTH (month, day, and year) Feb. 14, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
33	—	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Louisetta, Va.

PARENTS

10 NAME OF FATHER C. R. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Accomac Co. Va.

12 MAIDEN NAME OF MOTHER Alice Dobbins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Northumberland Co. Va.

14 Informant (Address) Roger E. Mc Gregor 2226 Madison Ave

15 Filed JUL 2 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1923

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1923, to July 2, 1923 that I last saw her alive on July 2, 1923, and that death occurred, on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Cellulitis of neck

(duration) yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? Wynne, Md.

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? .....

(Signed) Fr. J. Kirby, M. D.

, 19 (Address) 110 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mechanicsville Md. DATE OF BURIAL July 3 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E Biddle

Spec—12-23-21—E.B.R.S.—400 Blks.

D77209 HEALTH DEPARTMENT—CITY OF BALTIMORE D77209

47

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Gimbel

(a) Residence No. 1105 Peach Alley St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1880

7-AGE. 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Hungary

PARENTS.

10-NAME OF FATHER, Nick Sanderback

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Hungary

12-MAIDEN NAME OF MOTHER, Eva Buk

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Hungary

11- (Informant) Municipal Hospital Records

(Address)

15. JUL 2 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 1, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 13 1923 to July 1 1923 that I last saw her alive on July 1 1923 and that death occurred, on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast 2 yr.

Syphilis (B. W) duration ?

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (Terminal) (Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) N. Goldsmith M. D.

7-2-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross DATE OF BURIAL, July 5 1923

20-UNDERTAKER, Wm Corbin ADDRESS 501 E Lt. St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77210 D77210

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Park Hts ave & 7 mi St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Katie Lester Hoffman

(a) Residence No. Park Hts ave & 7 mi St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of C. C. Hoffman.

6-DATE OF BIRTH (month, day and year) May 1860

7-AGE,	If LESS than 1 day,
63 yrs. 7 mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)..... Home

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Chas C. Cameron

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Ella V. Mench

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Md.

14- (Informant)..... (Address).....

15. JUL 2 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 1 1923

17- I HEREBY CERTIFY, That I attended deceased from July 1, 19.., to July 1, 19..,

that I last saw h.. alive on July 1, 19..,

and that death occurred, on the date stated above, at 4.50 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Hypertension

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

7-2-, 1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Ridge Cem.	July 3, 1923.
20-UNDERTAKER.	ADDRESS.
John O. Mitchell	1201 N Fayette St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77211

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77211

CERTIFICATE OF DEATH.

9 129

1-PLACE OF DEATH St. Joseph Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E. Witte

(a) RESIDENCE NO. 2 Tyler st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. | How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/28/1866

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	57	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Piano Tuner 1886

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Henry Witte

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Arnold Hatton

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant (Address) Mrs. Lula Stanley 71 - Tyler St

15 Filed JUL 3 - 1923 G. H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7 - 1 - 1923

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1923, to July 1, 1923, that I last saw him alive on July 1, 1923, and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows: Myocardial Trapping

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis - about 4

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? P. S. S.

(Signed) Harold C. Pelham M. D.

7/1, 1923 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 7/4/23

20 UNDERTAKER Geo. D. Pentz & Co. — ADDRESS 1735 Harford Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Pds.

HEALTH DEPARTMENT—CITY OF BALTIMORE D77212

D77212

CERTIFICATE OF DEATH.

8 90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 N. Bethel ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine M. Bokel

(a) RESIDENCE NO. 1404 N. Bethel ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma A Bokel

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 58 Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work Home m/p

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER P Connolly

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER [redacted] July 4, 1923

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Emma A Bokel

(Address) 1404 N. Bethel St

15 JUL 3 - 1923 J L K Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1. 1923

17

I HEREBY CERTIFY, That I attended deceased from April 10, 1923 to July 1. 1923.

that I last saw h[illegible] alive on June 30. 1923

and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Do not know (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) General Oedema (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George A. Hartman M. D.

July 4, 1923 (Address) 1224 Mayfield Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mem Cathedral | DATE OF BURIAL July X 19 2

20 UNDERTAKER Robt J Johnson | ADDRESS 1442 W. Pratt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of infor-

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77213 CERTIFICATE OF DEATH. 161-00 D77213

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2603 Franklin ST.; 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Ritter

(Residence in Baltimore: No. 2603 Franklin St. ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Sgl

6-DATE OF BIRTH, July (Month) 2 (Day), 1923 (Year)

7-AGE, ...yrs....mos....ds.

If LESS than 1 day, 3 hrs. or X min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto - Md

PARENTS.

10-NAME OF FATHER, Geo E Ritter

11-BIRTHPLACE OF FATHER (State or Country), Balto Co - Md

12-MAIDEN NAME OF MOTHER Fredericka C Linder

13-BIRTHPLACE OF MOTHER (State or Country), Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo E Ritter

(Address) 2603 Franklin

15-

Filed JUL 3 191 1923 J. L. K. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 2 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 2 1923, to — 191....,
that I saw h— alive on — 191....,
and that death occurred, on the date stated above, at 3.30 A m.
The CAUSE OF DEATH* was as follows:

Premature Birth,
6 ½ mos.,
(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary).....
(Duration)....yrs....mos....ds.

(Signed) M D Brennan Lloyd M. D.
July 2, 1923 (Address) 626 N. Gilmor St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn DATE OF BURIAL, JUL 3 1923, 191...

20-UNDERTAKER Geo W Little ADDRESS 2700 EDMONDSON AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

D77214

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77214

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 E. 29th. St. ST., 9 WARD)

2-FULL NAME William Diver.

(a) RESIDENCE NO. 1701 E. 29th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Diver

6 DATE OF BIRTH (month, day, and year) June 5-1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.. min.
	80	0	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 5 yrs.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John A. Diver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Elizabeth Diederick (Address) 1701 E. 29th St

JUL 3 - 1923

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1923

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1921, to June 30 1923.

that I last saw him alive on June 30 1923

and that death occurred, on the date stated above, at 6.08 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral-Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John B. Owens M. D.

July (19 23 Address) 35-41 Potomac St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	July 4 1923

20 UNDERTAKER H. Sander & Sons ADDRESS 1710 Fleet St

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77215

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77215

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO. 7129

CITY OF BALTIMORE: (NO. ..... ST.: ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Elizabeth Siegrist

(a) RESIDENCE. NO. 811 N. Collington Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Siegrist

6 DATE OF BIRTH (month, day, and year) Dec 23, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Daniel Malkus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Margaret Kleinlein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George W. Siegrist

(Address) 811 N. Collington Ave.

15 Filed ..... 19 ..... Registrar

JUL 3 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1923, to July 1, 1923, that I last saw h e alive on July 1, 1923, and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis of nephritis; apoplexy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at residence

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & laboratory

(Signed) Isidor D. Fry M. D.

19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 4 '23
20 UNDERTAKER	ADDRESS
N. Sanders & Sons	1710 Fleet St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Shawen)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77216

D77216

CERTIFICATE OF DEATH.

X 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Shawen

(a) RESIDENCE NO. Glyndon, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Leonidus Shawen

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Isabell Albert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Lula Biel (Address) Glyndon Md

15 Filed JUL 3 - 1923 J. L. K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-1-1923

17

I HEREBY CERTIFY, That I attended deceased from 6-22-, 1923, to 7-1-, 1923,

that I last saw her alive on 7-1-, 1923,

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pelvic Viscera

Omentum, entrion, peritoneal wall.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6-27-23

Was there an autopsy? no

What test confirmed diagnosis? Operative findings

(Signed) H. O Carr, M. D.

7/1, 1923 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: July 3 1923

20 UNDERTAKER: J. F. Elmo — ADDRESS: Reisterstown Md

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D77217

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-001

D77217

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 58 E. Randall St. ST., 23 WARD)

2-FULL NAME Thomas H. Brown

(a) RESIDENCE NO. 58 E. Randall St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. 3 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 13 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Thomas H. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Nettie E. Kendall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs Brown

(Address) 58 E. Randall

15 JUL 3 - 1923

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1923

17 I HEREBY CERTIFY, That I attended deceased from June 12 1923 to July 1 1923.

that I last saw him alive on July 1 1923.

and that death occurred, on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

7 (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Edema Arms

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) H. Harrison, M. D.

(Address) 1 E. Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	7/3 1923
20 UNDERTAKER J. Frew McCully	ADDRESS 130 E. Fort

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77218

CERTIFICATE OF DEATH.

31 ✓ D77218

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1112 W Lexington St. ST.; 21 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gerhard W Mugent

(Residence in Baltimore: No. 1112 W Lexington St. St.; 37 yrs., 9 mos. 20 ds.)

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state clearly all information should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Widower

6-DATE OF BIRTH, Sept. 11, 1885
(Month) (Day) (Year)

7-AGE, 37 yrs. 9 mos. 20 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Policeman
(b) General nature of industry, business, or establishment in which employed (or employer): 161

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James Mugent

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER, Sarah Meyers

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. O'Connor

(Address) 1147 W Lexington St

15- JUL 3 - 1923 Filed ....., 191.....
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 30, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 14 1923 to June 30 1923, that I saw h[illegible]alive on June 30 1923, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John G. Schwarze M. D.

June 30, 1923 (Address) 1112 W Lexington St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Pk Cem — DATE OF BURIAL, 7/4, 1923

20-UNDERTAKER J. F. McCully — ADDRESS 430 E Fort

Spec.—8-24-14—M. & T.—2000 Bks.

D77219 HEALTH DEPARTMENT—CITY OF BALTIMORE D77219

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — REGISTERED No. C 16 90

CITY OF BALTIMORE: (No. 1309 Mosher ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Green

(Residence in Baltimore: No. 1309 Mosher St.; 19 yrs., ... mos. ..... da.)

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept 1, 1870 (Month) (Day) (Year)

7-AGE, 53 yrs. 10 mos. 1 da. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Race Horse
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Man

9-BIRTHPLACE, (State or Country), Texas

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Green

(Address) 309 Mosher St.

JUL 3 - 1923

Filed ....., 191.. Registrar. H. Case

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 2, 1923 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to July 2, 1923, that I saw ... alive on June 30, 1923, and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... yrs. 2 mos. ..... da.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) ..... yrs. 2 mos. ..... da.

(Signed) Geo. J. Cary M. D.

July 3, 1923 (Address) 5-10 Mosher

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Sherdal Lodge DATE OF BURIAL, July 3, 1923

20-UNDERTAKER Samuel Handy ADDRESS 2216 Eddie

Spec.—1-10-21—M&T—1500 Bks.

(Simmons)

D77220 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D77220

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 205 N Amity ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Simmons

(a) RESIDENCE NO. 205 N Amity ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE Clubroom

6 DATE OF BIRTH (month, day, and year) Clubroom 1898

7 AGE Years 25 Months Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Clubroom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Clubroom

12 MAIDEN NAME OF MOTHER Clubroom

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Clubroom

14 Informant Lewis Thompson (Address) 205 Amity

15 Filed JUL 3 - 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) January 9 1923

17 I HEREBY CERTIFY, That I attended deceased from January 6, 1923, to January 9, 1923, that I last saw h alive on January 8, 1923, and that death occurred, on the date stated above, at 6 15 m.

The CAUSE OF DEATH* was as follows:

Clubroom 1 B C

Pneumonia Lyft.

(duration) 1/ yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Walter D Jones M. D.

, 19 (Address) 1618 W. Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL July 12 1923

20 UNDERTAKER Samuel J Hendley ADDRESS Balto

MARK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77221

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114 D77221

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Sheets alley ST., 17 WARD)

2-FULL NAME Mary Harris

(a) RESIDENCE NO. 1014 Sheets alley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Harris

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 57 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home 1537

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John Harris

(Address) 1014 Sheets Alley

15 Filed JUL 3 1923, 19.. Registrar A. Hall

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sunday July 1st 1923

17

I HEREBY CERTIFY, That I attended deceased from May 23rd, 19 23, to July 1st, 19 23.

that I last saw h alive on June 29, 19 23.

and that death occurred, on the date stated above, at 1 A.M. m.

The CAUSE OF DEATH* was as follows:

Apoplexy Cerebral

(duration) yrs. 1 mos 4 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical signs

(Signed) Dr. Hunter, M. D.

, 19 (Address) 607 Cherry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: July 4 1923

20 UNDERTAKER: Samuel Wemsley — ADDRESS: 1138 Bank

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D77222 HEALTH DEPARTMENT—CITY OF BALTIMORE D77222

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1133 W Saratoga ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Perry

(a) RESIDENCE No. 1133 W Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (~~HUSBAND of~~) (or) WIFE of: John Perry

6 DATE OF BIRTH (month, day, and year): — — 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Tolbert Ct Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: Harriett Tillman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Frank Byers

(Address) 1311 N Carey St

15 Filed JUL 3 1923 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Feby 4, 1923, to June 30, 1923, that I last saw her alive on June 29, 1923, and that death occurred, on the date stated above, at 7.35 a m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiac Disease

(duration) Indeterminable

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. H. Howell, M. D.

7/1, 1923 (Address) 119 N Arrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 5 1923
20 UNDERTAKER: Samuel Hemsley	ADDRESS: W Balto

Spec.—1-10-21—M&T—1500 Bks.

D77223 HEALTH DEPARTMENT—CITY OF BALTIMORE D77223

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 D. Pratt ST. 17 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Lloyd

(a) RESIDENCE NO. 718 D. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) January 6th 1910

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
13	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Wesley Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Cora Rowtree

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Cora Randolph (Address) 718 D. Pratt St.

15 Filed JUL 3 1923 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30th 1923

17

I HEREBY CERTIFY, That I attended deceased from April 24 1923 to June 30 1923.

that I last saw h[illegible] alive on June 29 1923,

and that death occurred, on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Ch.

Chron —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) No contributing Cause (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 718 D. Pratt St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

19 (Address) 72 Lynwood Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem.	July 4 1923
20 UNDERTAKER Samuel F. Hensley	ADDRESS 778 N. Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Pks.

D77224

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77224

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Volunteers of America Hospital ST. 19 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marion Eva Ahrens

(a) RESIDENCE. No. 1445 Henry ST., WARD. 24
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert C. Ahrens

6 DATE OF BIRTH (month, day, and year) Oct 27 1878

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
44	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) Phila
(State or country) Pa.

PARENTS

10 NAME OF FATHER Hagenbuch

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa

12 MAIDEN NAME OF MOTHER Susie Eckhardt

13 BIRTHPLACE OF MOTHER (city or town) Easton
(State or country) Pa.

14 Informant Robert C. Ahrens
(Address) 1445 Henry St.

15 Filed JUL 3 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1923

17

I HEREBY CERTIFY, That I attended deceased from June 22, 1923, to July 1, 1923, that I last saw h alive on July 1, 1923 and that death occurred, on the date stated above, at 11.15 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of July 26 - 23

Was there an autopsy? no

What test confirmed diagnosis? microscopic

(Signed) Albert F. Conway, M. D.

, 19 (Address) Vol. of America Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	7/3/1923

20 UNDERTAKER E. J. Fanning & Son ADDRESS 1460 Battery Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

RESERVED FOR BINDING

Spec.—1-10-21—M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77225 129 D77225

CERTIFICATE OF DEATH.

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 N. Mrs ST., 43 WARD)

2-FULL NAME William Wright

(a) RESIDENCE No. 203 N. Mrs ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 25th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George W. Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Clarina E Mader

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Md

14 Informant Mrs L. Wright

(Address) 203 W. First St.

15 JUL 3 - 1923 J. L. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1923

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1923, to July 2, 1923.

that I last saw him alive on July 2, 1923

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:-

Chronic interstitial nephritis

unknown

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted — if not at place of death?

Did an operation precede death? no

Was there an autopsy? no

What test confirmed diagnosis? Clin

(Signed) W. McElroy M. D.

7/2, 1923 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	July 5 1923
20 UNDERTAKER E Schlosman & Son	ADDRESS 1039 Hanover St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PRESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D77226 HEALTH DEPARTMENT—CITY OF BALTIMORE D77226

(Moff)

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 611 [illegible] Hospital (ST.) W. Madison (WARD)

FULL NAME Julia Angelina Moff

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 210 N. Washington ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tony Dominick Moff

6 DATE OF BIRTH (month, day, and year) Aug 21 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Stephen Chiocatelle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Lapdmia Chiocatelle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Dominick Moff
(Address) 210 N Washington

15 Date JUL 3 1923 [signature]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1923

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1923, to July 2, 1923, that I last saw h— alive on July 2, 1923, and that death occurred, on the date stated above, at 6 50 am.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos 8 ds.

CONTRIBUTORY (Secondary) Pregnancy

(duration) — yrs. 8 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? — no

What test confirmed diagnosis? —

(Signed) J. A. Schneider, M. D.

19 (Address) U. of M. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincents — DATE OF BURIAL July 4 1923

20 UNDERTAKER Wendell Appelson — ADDRESS 3?3 [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PREPARED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

D77227

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77227

CERTIFICATE OF DEATH.

51

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 783 W Saratoga ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Sheppard

(a) RESIDENCE NO. 783 W Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed or divorced (HUSBAND of or) WIFE of Emmanuel Sheppard

6 DATE OF BIRTH (month, day, and year) — — 1869

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Samuel Edwards

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Emmanuel Sheppard

(Address) 783 W Saratoga St

15 Filed JUL 3 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1923, to July 2, 1923, that I last saw her alive on June 30, 1923, and that death occurred, on the date stated above, at 4. a m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatic Fever

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ulcerative Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What ~~test confirmed~~ diagnosis?

(Signed) W. A. Fowler, M. D.

July 3, 1923 (Address) 1921 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL July 4 1923

20 UNDERTAKER Brown Weland & Schaub

ADDRESS 114 W

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PRESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE (Monte)

D77228 D77228

CERTIFICATE OF DEATH. 162

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 2210 E North Ave ST.: 8 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Monte

(a) RESIDENCE. No. 2210 E North Ave ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 5 hrs ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		5 hrs.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo Monte

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Florence Luther

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant George Monte, Sr.
(Address) 2210 E North Ave

15 Filed JUL 3 - 1923 J. L. H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/2/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 7/2/ 1923, to 7/2/ 1923, that I last saw h[illegible] alive on 7/2/23 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:
Congenital atelectasis
Cmo premature labor

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George A. Bender, M. D.

7/2, 1923 Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[redacted]	July 3 1923

20 UNDERTAKER ADDRESS
James Dignan & Son 1005 Park Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77229

HEALTH DEPARTMENT—CITY OF BALTIMORE (Monte)

CERTIFICATE OF DEATH.

8 162 D77229

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No 2210 E North Ave ST.; 8 WARD)

2-FULL NAME Florence Monte

(a) RESIDENCE. No. 2210 E North Ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 hrs. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years — Months — Days — If LESS than 1 day hrs. 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Monte

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Florence Webber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George Monte
(Address) 2210 E North Ave

15 [illegible]

JUL 3 - 1923

F. L. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/2/ 1923

17

I HEREBY CERTIFY, That I attended deceased from 7/ 1/ 23, 19.., to 7/ 2/ 23, 19.., that I last saw h[illegible] alive on 7/ 2/ 23, 19.., and that death occurred, on the date stated above, at 7 15 P. m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis.
(16 mos premature labor)
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George A Bauder M. D.

(Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery — DATE OF BURIAL: July 3 1923

20 UNDERTAKER: James Dignan & Son — ADDRESS: 1001 E. Pacca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77230 HEALTH DEPARTMENT—CITY OF BALTIMORE D77230

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Batavia & Holder Aves. St. 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Apolonia F. Rolle

(Residence in Baltimore: No. Batavia & Holder Aves. St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	Widow

6-DATE OF BIRTH, March 6/1862 1.....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
61 yrs. 3 mos. 26 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Herman Hartman

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Herman Rolle

(Address) Batavia & Holder Aves

15- JUL 3 - 1923 192.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 2/23 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) S H Rollins M. D.
(Coroner)

7/3/23 192.... (Address) 505 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Holy Redeemer Cemetery July 4 1923

20-UNDERTAKER, ADDRESS

Henry Hoerle Son 1301 E. Eager

Spec.—1-10-21—M&T—1500 Bks.

D77231

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77231

94

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 N Washington ST. 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin H. Nelson Jr

(a) RESIDENCE NO. 1319 N. Washington ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 21 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 11 '23

7 AGE — Years: — Months: — Days: 21 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Martin H. Nelson Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Anna Unbo

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): Martin H. Nelson Sr 1319 N. Washington St

15 JUL 3 - 1923 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 2nd 1923

17

I HEREBY CERTIFY, That I attended deceased from June 11, 1923, to July 2, 1923

that I last saw h[illegible] alive on July 2, 1923

and that death occurred, on the date stated above, at 7 04 a. m.

The CAUSE OF DEATH* was as follows:

Enlarged Thymus

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exam

(Signed) E E Kelly, M. D.

July 2, 1923 (Address) 100 N Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: July 3rd 1923

20 UNDERTAKER: Philip Herrig — ADDRESS: 2006 Adams

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77232

CERTIFICATE OF DEATH.

162 D77232

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West End Maly St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Betty Jane Thomas

(Residence in Baltimore: No. West End Maly Hospl St.; ..... yrs., ... mos. 6 ds.)

1623 Calvert St.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, 6 (Month) - 29 (Day) - 23, 1 (Year)

7-AGE, ... yrs. ..... mos. 5 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), West End Maly

PARENTS.

10-NAME OF FATHER, Harvey Thomas

11-BIRTHPLACE OF FATHER (State or Country), Pa.

12-MAIDEN NAME OF MOTHER Lillie Hackett

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harvey Thomas

(Address) 1623 N. Calvert

15-

Filed JUL 3 - 1923, 191.... J. S. K.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 7 (Month) - 3 (Day) - 23, 191... (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29 1923, to July 3 1923, that I saw her alive on July 3 23 191, and that death occurred, on the date stated above, at 10 20 m.

The CAUSE OF DEATH* was as follows:

Mental depression.

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Parr Bu M.D. Glenn Grove M. D.

7/3, 1923. (Address) Franklin Sq. Hosp.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. 5 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence 1623 N. Calvert

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, 7/3 1923

20-UNDERTAKER W. M. Cook — ADDRESS 502 E. North

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD, AND MUST BE WRITTEN WITH INDELIBLE INK

D77233 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77233

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 2100 Etting St., St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Chase

(Residence in Baltimore: No. 2100 Etting St. St.; yrs. 10 mos. 30 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	colored	single

6-DATE OF BIRTH. July 3 1922
(Month) (Day) (Year)

7-AGE. ....yrs. 11 mos. 30 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS

10-NAME OF FATHER. Howard Chase.

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Viola Chase

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

I HEREBY CERTIFY, THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Viola Chase

(Address) 2100 Etting St.

15- JUL 3 - 1923 Filed ..... 192.... [signature] Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 2 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, found that said deceased came to ....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) .... yrs. .... mos. 2 ds.

CONTRIBUTORY (Secondary) no history

(Duration) .... yrs. .... mos. .... ds.

(Signed) [signature] M. D.
(Coroner)

192.. (Address) ....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, July 3rd 1923

20-UNDERTAKER, James E. Wright — ADDRESS 1364 W. Lanvale

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77234

CERTIFICATE OF DEATH. 101-002

D77234

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1412 Jasper (St.:) 19 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo Tait

(a) RESIDENCE. NO. 1412 Jasper Pl St., 19 Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 1 1825

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	97			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Scotland

PARENTS

10 NAME OF FATHER Geo Tait

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER Ann Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Chas Strum
(Address) 1412 Jasper Place

JUL 3 - 1923

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/2/23. 19

17 I HEREBY CERTIFY, That I attended deceased from 7/2/23. 19 to 7/2/23. 19 ,
that I last saw him alive on 7/2/23 19 ,
and that death occurred, on the date stated above, at 4:35 p. m.
The CAUSE OF DEATH* was as follows:

Terminal Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Old age - Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. H. Mencken, M. D.

7/3/23. 19 (Address) 3028 Fowler

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National	July 6 19 23

20 UNDERTAKER: John J. Fields ADDRESS 200 N. Fremont

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77235

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D77235

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Flores (Lopez?)

(a) RESIDENCE NO. 714 Redwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Peter Flores

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Aglia Chambira

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Peter Flores

(Address) 714 Redwood ave

Filed JUL 3 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1923

17

I HEREBY CERTIFY, That I attended deceased from June 19, 1923, to July 2, 1923, that I last saw him alive on July 2, 1923, and that death occurred, on the date stated above, at 5:00 P m.

The CAUSE OF DEATH* was as follows:

Encephalitis.

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary) acute Bronchitis

(duration) — yrs. — mos. 15 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) B Macfarlan M. D.

7/3/23 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 7-3-1923

20 UNDERTAKER David Easton

ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77236

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D77236

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 N. Exeter ST., 5 WARD)

2-FULL NAME Morris Lurie

(a) RESIDENCE NO. 15 N. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant S Goldberg

(Address) 15 N Exeter st

15 JUL 3 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1923

17 I HEREBY CERTIFY, That I attended deceased from 7/2, 1923, to 7/2, 1923, that I last saw him alive on ", 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? Date of

Was there an autopsy? Autopsy

What test confirmed diagnosis?

(Signed) A. G. Rudow M. D.

7/3, 1923 (Address) 618 E Fayette st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebw Herring Run — DATE OF BURIAL 7/3 1923

20 UNDERTAKER Sol Levinson Bro — ADDRESS 1127 E Baltimore st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D77237

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77237

CERTIFICATE OF DEATH.

1-PLACE OF DEATH In the House of — 188-003

CITY OF BALTIMORE: (No. 619 N. Fremont St. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John R. Moss.

(a) RESIDENCE NO 1038 Wilmer Ally ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 21, 1913

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
10 yrs.	3	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER J. R. Moss Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Mary Moss
(Address) 1038 W Ilmer Ally.

15 JUL 3 - 1923 J. D. K. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull.
automobile accident.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. E. Hennessy, M. D.
(Coroner.)

July 1, 1923 (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	7/3 1923
20 UNDERTAKER Samuel Wemley	ADDRESS 578 W Baltimore

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FEE TY A S·A F K

Spec.—1-10-21—M&T—1500 Bks.

16457 238

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77238

CERTIFICATE OF DEATH

X 118-002

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No.) ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rudolph Gerlach

(a) RESIDENCE NO. Kolling Road ST., ... WARD Catonsville Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Elizabeth Gerlach

6 DATE OF BIRTH (month, day, and year) Sept 18-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jeweler

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wetzlar Germany

PARENTS

10 NAME OF FATHER Otto Gerlach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christine Hoerdt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed JUL 3 - 1923 J. L. K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1923

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1923, to July 1, 1923,

that I last saw him alive on July 1, 1923,

and that death occurred, on the date stated above, at 10.30 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 20.

Was there an autopsy? Yes

What test confirmed diagnosis? operation

(Signed) Warfield M Theobald, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	July 4 1923
20 UNDERTAKER Dorsey & Fox	ADDRESS 1225 E Oliver St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D77239

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77239

CERTIFICATE OF DEATH.

118-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 613 S. Belnord Ave St. 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Zametzer

(a) Residence No. 613 S. Belnord Ave St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Elizabeth Zametzer

6-DATE OF BIRTH (month, day and year) Dec. 11-1859

7-AGE. 63 yrs. 7 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. John Zametzer Sr.

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Annie B. Wagner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-

(Informant) Elizabeth Zametzer

(Address) 613 S. Belnord Ave

15-

JUL 3 - 1923

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 2-1923

17- I HEREBY CERTIFY, That I attended deceased from June 29 1923 to July 2 1923

that I last saw him alive on July 2 1923

and that death occurred, on the date stated above, at 2.50 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Gangrene

Stercoma (Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. L. Lay M. D.

7-6, 1923 (Address) 701 Eutaw Pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt. Carmel Cemetery	July 5 1923
20-UNDERTAKER. Zirkler & Zirkler	ADDRESS 1737 E. Eager St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77240

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D77240

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Womans Hospital

CITY OF BALTIMORE. NO. ..... ST., 22 (WARD)

2-FULL NAME Laura Francis Salfner

(a) RESIDENCE NO. 624 Wyndhurst Ave ST., 27 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 7 mos. 19 ds. How long in U. S., if of foreign birth? 56 yrs. 7 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Howard R. Salfner

6 DATE OF BIRTH (month, day, and year): Nov 12, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Md. Baltimore County.

PARENTS

10 NAME OF FATHER: John T. Kelley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Eliza Considine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Howard R. Salfner

(Address) 624 Wyndhurst Ave

15 Filed JUL 3 - 1923 Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1 1923

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1923, to July 1, 1923.

that I last saw h[illegible] alive on July 1, 1923.

and that death occurred, on the date stated above, at 5.50 p m.

The CAUSE OF DEATH* was as follows:

Chronic Hypertinitis
Arteria-Sclerosis
Hypertension

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis? Clinical Studies

(Signed) Norman E. Tanzenbaum M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: July 5 1923

20 UNDERTAKER: STEPHEN E. MOWEN COMPANY (WILLIAM F. MOWEN, Successor)

ADDRESS 108 W. North Ave

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D77241

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77241

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3011 West North ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Warner

(a) Residence No. 3108 Baker st St., Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 0 mos. 4 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) June 28/1881

7-AGE, 42 yrs. 0 mos. 4 ds. If LESS than 1 day, —hrs. or. —min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town). Baltimore
(State or Country), Md.

PARENTS

10-NAME OF FATHER. John Warner

11-BIRTHPLACE OF FATHER (city or town). Littletown
(State or Country), Md

12-MAIDEN NAME OF MOTHER. Margaret Steil

13-BIRTHPLACE OF MOTHER (city or town)
(State or Country), Germany

14- (Informant) Herbert H. Warner

(Address) 3011 West North ave

15- Filed JUL 3 - 1923 ROBERT R. KRAUT, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 2nd 1923

17- I HEREBY CERTIFY, That I attended deceased from June 1st 1923 to July 2nd 1923

that I last saw h. alive on July 1st 1923

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(Duration) yrs. 1 mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? dont know

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Lopez H. Dubert M. D.

July 3, 1923 (Address) 1100 W. Lafayette ave

State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park — DATE OF BURIAL. 7/5/23

20-UNDERTAKER. Geo. Weber & Son — ADDRESS 2503 Edmondson ave

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman*, etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Lethargic

Spec—12-23-21—E.B.R.S.—400 Blks.

D77242

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D77242

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 714 North Fulton St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. William Taylor Holmes

(a) Residence No. 714 North Fulton St., Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 11 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Holmes

6-DATE OF BIRTH (month, day and year) July 28-1849

7-AGE. 74 yrs. 11 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Sheet Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R.

(c) Name of employer. Retired

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Don't Know

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Don't Know

14- (Informant) Mary L. Holmes

(Address) 714 W. Fulton ave

15- Filed JUL 3 - 1923 ROBERT R. KRAMER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 1st 1923

17- I HEREBY CERTIFY, That I attended deceased from June 15 1923 to July 1 1923

that I last saw h.. alive on June 30 1923

and that death occurred, on the date stated above, at 12 0 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Carcinoma

contributory (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Tumor in abdomen and Pathological examination from exploratory incision

(Signed) Irving Lieber M. D.

, 19 (Address) 108 E. North ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park

DATE OF BURIAL. 7/5/23, 19....

20-UNDERTAKER. Geo. Weber & Son

ADDRESS 2503 Edmondson ave

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. USE BLACK INDELIBLE INK—THIS IS A PERMANENT RECORD.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77243

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77243

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 N Rutland ave St. 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Perron

(a) RESIDENCE. No. 8 N Rutland ave ST. WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col.	Married

5a If married, widowed, or divorced HUSBAND of ~~(or), WIFE of~~ Eliza Perron

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer Pennsylvania Steel Co

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Eliza Perron (Address) 8 N Rutland ave

15 Filed JUL 3 - 1923 ROBERT R. KRAUSE Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1 July 1923

17 I HEREBY CERTIFY, That I attended deceased from June, 1923, to July, 1923, that I last saw him alive on June 30, 1923, and that death occurred, on the date stated above, at 8.N 9 m.

The CAUSE OF DEATH was as follows:*

Pulmonary Tuberculosis

General weak

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Johns Hopkins.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Wrayfield Bode, M. D.

19 (Address) 426 N. Carolina ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	July 3 1923

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS 220 Ashland ave

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77244

CERTIFICATE OF DEATH.

40 D77244

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 520 William ST. 24 (WARD)

2-FULL NAME Emma Cath Bailey

(a) RESIDENCE. No. 1520 William ST., 24 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced (or) WIFE of Wm F. Bailey

6 DATE OF BIRTH (month, day, and year) 11. 3. 1855

7 AGE Years 68. Months 8 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Accomack Co. Va

PARENTS

10 NAME OF FATHER John Willett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Thornton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Accomack Co Va

14 Informant Mrs Lou Brickhouse

(Address) 1520 William Sister

15 JUL 3 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7. 3, 1923

17 I HEREBY CERTIFY, That I attended deceased from 7. 1, 1923, to 7. 3, 1923, that I last saw h e alive on 7. 2, 1923, and that death occurred, on the date stated above, at 4. a m.

The CAUSE OF DEATH* was as follows:

Myocarditis (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Gastritis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Turlington, M. D.

7/3, 1923 (Address) 1820 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: 7/5 1923

20 UNDERTAKER: J. F. McCully — ADDRESS: 130 E. Fay

IN CASE PENCIL, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77245

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77245

1-PLACE OF DEATH U.S. Marine Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howell Dunn

(a) RESIDENCE NO. U.S. Marine Hosp St. Ward (If non-resident give city or town and State) Raleigh N.C

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. 30 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
30				

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hosp. Records.
(Address)

15 Filed JUL 3 - 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1 , 1923, to July 2 , 1923.

that I last saw he alive on July 2 , 1923.

and that death occurred, on the date stated above, at 10.45 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Path. findings

(Signed) M.A. Porter , M. D.

, 19 (Address) Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Raleigh N.C	July 4 1923

20 UNDERTAKER Mrs Robert L. Elliott ADDRESS 1725 Eastern Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 D-77246

164580 12.40 A.M. HEALTH DEPARTMENT—CITY OF BALTIMORE 118-002 D77246

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanora Carter.

(a) RESIDENCE No. 807 N. Dunham ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem. | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alexander Carter (husb)

6 DATE OF BIRTH (month, day, and year): Nov. 28, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	26	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife.

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): — Md.

PARENTS

10 NAME OF FATHER: Samuel Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Lavinia.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUL 3 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 3 1923

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1923 to July 3, 1923. that I last saw her alive on July 3, 1923 and that death occurred, on the date stated above, at 12.40 A.m.

The CAUSE OF DEATH* was as follows:

Pelvic peritonitis —

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Intestinal obstruction —

partial (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 2-1923

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) Meyer E. Goldblatt, M. D.

, 19 (Address) Johns Hopkins Hosp. City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lamel Cemetery — DATE OF BURIAL: July 5 1923

20 UNDERTAKER: Mrs R. A. Elliott — ADDRESS: 172 Eastlander

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77247

HEALTH DEPARTMENT—CITY OF BALTIMORE

128 D77247

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma Moore

(Residence in Baltimore: No. 923 Hubert Ct St. 7 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Unknown 1.....
(Month) (Day) (Year)

7-AGE. 38 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md.

PARENTS

10-NAME OF FATHER, Wm White

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Mary Purnell

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary White

(Address) 923 Hubert Ct

15- Filed. JUL 3 - 1923 192.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, June 30 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, or Inquiry.) thereon and from the evidence obtained by said Inquest, and from Inquest (Inquest, or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ....yrs. ....mos. 1 d. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Wm P. Horn M. D.
(Coroner)

July 3rd 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, if deaths were due to Violent Causes, state (1) Means of Injury; and whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Forest Cemetery	July 5 1923
20-UNDERTAKER,	ADDRESS
Mark R. McElliott	1725 Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77248

CERTIFICATE OF DEATH.

128 D77248

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 2128 W. Saratoga Street St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Martha Mary Manjean

(a) Residence No. 2128 W. Saratoga St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Frank P. Manjean

6-DATE OF BIRTH (month, day and year) Jan. 3, 1873

7-AGE.	If LESS than 1 day.
50 yrs. 5 mos. 28 ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), California

PARENTS.

10-NAME OF FATHER, John Davis

11-BIRTHPLACE OF FATHER (city or town) (State or Country), England

12-MAIDEN NAME OF MOTHER, Rachel Brownley

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pa.

14- (Informant) Frank P. Manjean

(Address) 2128 W. Saratoga St.

15- JUL 3 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 1, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 30, 1923 to July 1, 1923 that I last saw her alive on June 30, 1923 and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. J. Cashman M. D.

7/2, 1923 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. City Cemetery

DATE OF BURIAL, 7/4, 1923

UNDERTAKER. Engel & Early

ADDRESS Fulton & Fayette

This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

No other abnormal condition

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77249

CERTIFICATE OF DEATH.

74-001

D77249

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 311 S Chester ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Piechowiak

(a) RESIDENCE NO. 311 S Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Piechowiak

6 DATE OF BIRTH (month, day, and year) Jan 6 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	59	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Biskupski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Michael Piechowiak

(Address) 311 S Chester

Filed JUL 3 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1923

17 I HEREBY CERTIFY, That I attended deceased from July 2nd, 1923, to July 2nd, 1923, that I last saw h alive on July 2nd, 1923, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Hemorrhage)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) A T Reis, M. D.

July 3rd, 1923. (Address) 24 E Mou

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	July 5 1923
20 UNDERTAKER	ADDRESS
John M Weber	1803 Banks

MARK PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77250

CERTIFICATE OF DEATH.

1131

D77250

REGISTERED No.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1130 Riverside Ave ST. WARD)

2-FULL NAME Peter J. Slaine

(a) RESIDENCE No. 1130 Riverside Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a ~~Married~~, widowed, ~~divorced~~ HUSBAND of ~~(or) WIFE of~~ Alice Higgins

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boss

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Peter Slaine

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Bridget Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Peter Slaine

(Address) 1130 Riverside Ave

15 Filed JUL 3 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 31, 1922 to June 2, 1923

that I last saw h~~e~~ alive on June 1, 1923

and that death occurred, on the date stated above, at 3A m.

The CAUSE OF DEATH* was as follows:

Abscess of Kidney

Indigestion (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R E Campbell M. D.

June 3, 1923 (Address) 644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Cem DATE OF BURIAL 7/4 1923

20 UNDERTAKER Fahey House ADDRESS 315 Light St

IN INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77251

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D77251

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 N Fulton ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma V Salmon

(a) RESIDENCE NO. 1629 N Fulton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William R Salmon

6 DATE OF BIRTH (month, day, and year): May 7 1860

7 AGE: Years 63 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: John B Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Seitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wm R. Salmon

(Address) 1629 N Fulton

15 Filed JUL 3 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 2 1923

17 I HEREBY CERTIFY, That I attended deceased from June 30 1923 to July 2 1923.

that I last saw h alive on July 2 1923

and that death occurred, on the date stated above, at 1-40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Anemia

(duration) — yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Chemical

(Signed) J. W. Harris M. D.

1923 (Address) 1278 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn July 5 1923

DATE OF BURIAL

20 UNDERTAKER: Wm Cook

ADDRESS 502 E. Fayette

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77252

CERTIFICATE OF DEATH.

185 D77252

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2832 Alameda Blvd. (St.) 9 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret Whittle

(a) RESIDENCE. No. 2832 Alameda St. Balt. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W	widowed

5a If married, widowed, or divorced
BUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1839. 4/8

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	0	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — House Work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Daniel Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Annie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant J. L. Whittle
(Address) 1934 Fortieth St.

15 Certificate received JUL 3 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1923

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1923, to July 3, 1923, that I last saw her alive on July 2, 1923, and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Fracture Rt. Femur
(Surgical needs)

(duration) yrs. 14 mos. da.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. L. Zimmerman M. D.

July 1923 (Address) 2758 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	7/5/1923

20 UNDERTAKER — ADDRESS

Wm. Cook - 502 E. Northern

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Certificate - face
Stapled white
Getting out of file

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77253

179

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 Lemmon ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosalie L. Barlow

(a) RESIDENCE NO. 714 Lemmon ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Feby 19 1922

7 AGE: Years 1 Months 4 Days 15 If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Edward Barlow

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bristol Penn.

12 MAIDEN NAME OF MOTHER: Harriet Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Port News Va

14 Informant: Mrs Edward Barlow

(Address) 714 Lemmon St

15 JUL 4 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 4 1923

17

I HEREBY CERTIFY, That I attended deceased from July 1 1923 to July 4 1923.

That I last saw her alive on July 3 1923,

and that death occurred, on the date stated above, at 12-30 a m.

The CAUSE OF DEATH* was as follows:

Contusions

Of Carmer J. Mowrey

(duration) yrs. mos 12 hrs

CONTRIBUTORY (Secondary) Burns

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Irvin Etkupfer M. D.

, 1923 (Address) 700 E. N. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: July 4 1923

20 UNDERTAKER: Chas. S. Black — ADDRESS: 742 W. North ave

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accident – Pulled pot of Scalding Coffee over it's self.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77254

CERTIFICATE OF DEATH.

D77254

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1209 Edward ST. 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A Knight

(a) RESIDENCE. NO. 1209 Edward ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER william wright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER mary smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore md

14 Informant carrie wright
(Address) 1209 edward st

15 JUL 4 - 1923 ROBERT R. KRANTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 24, 1923, to July 1, 1923, that I last saw h.. alive on July 1, 1923, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 3 mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(duration) yrs. 3 mos. 7 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ~

(Signed) J. Edward Fisher, M. D.

7-1-1923 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet cemetery	July 4 1923
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans st

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77255

D77255

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No 1022 N. Lombard ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Lindemeyer

(a) RESIDENCE. No. 1022 N. Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., If of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Sweikert Lindemeyer

6 DATE OF BIRTH (month, day, and year) Apr 25 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron moulder

(b) General nature of industry, business, or establishment in which employed (or employer) Iron

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm Lindemeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christine Steinecker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs R. Lindemeyer

(Address) 1022 N Lombard

15 JUL 4 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1923, to July 2, 1923

that I last saw him alive on July 2, 1923

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Phthisis

(duration), 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Collapse

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Lee Lemmon, M. D.

July 3, 1923 (Address) 1 East Lexington

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	July 5 " 1923

20 UNDERTAKER	ADDRESS
Peter F. J. Cowan	90 Hollins St

INSTRUCTIONS TO PHYSICIANS AND UNDERTAKERS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. D77256

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77256 CERTIFICATE OF DEATH. 816-001 D77256

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Morris Lydon

(a) RESIDENCE NO. 1317 W. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 2-1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	2	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Richard J Lydon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Annie Knipp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mr Richard J Lydon

(Address) 931 N Fountain Ave

15 Filed JUL 4 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1923

17

I HEREBY CERTIFY, That I attended deceased from June 22, 1923, to July 3, 1923, that I last saw him alive on July 3, 1923, and that death occurred, on the date stated above, at 11:20 a m.

The CAUSE OF DEATH* was as follows:

Meningitis (Mixed etiology streptococcus & pneumococcus) extension from otitis media

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary) Pneumonia, terminal

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) J W Feeney, M. D.

July 4, 1923 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Ursula's Cem	July 5 1923
20 UNDERTAKER John J Conway & Son	ADDRESS 70 Holliday St

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77257

CERTIFICATE OF DEATH. 7H-001

D77257

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5010 Belleville Ave ST., 28 WARD)

2-FULL NAME Lizzie R. Wonder

(a) RESIDENCE No. 5010 Belleville Ave ST., WARD.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~
~~HUSBAND~~ (or) WIFE of John S. Wonder

6 DATE OF BIRTH (month, day, and year) July 1, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	78	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Albert H. Kelsey
(Address) 5010 Belleville Ave

15 JUL 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) JUL 3 1923

17 I HEREBY CERTIFY, That I attended deceased from July 2nd, 1923, to July 3rd, 1923.
that I last saw her alive on July 3rd, 1923.
and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:
Hemorrhage of brain (Apoplexy)
Arteriosclerosis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Senility & Prostate trouble (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical

(Signed) Edward ..... M. D.

JUL 3 1923 19 (Address) 1602 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Western DATE OF BURIAL July 6 1923

20 UNDERTAKER Geo W Little ADDRESS 2700 EDMONDSON AVE

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77258

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77258

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 20 162 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vernon Wilhelm Laage

(Residence in Baltimore: No. 2233 Wilkens Ave. St.; yrs. ..... mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	

6-DATE OF BIRTH. June 22/23 1..... (Month) (Day) (Year)

7-AGE. ..... yrs. ..... mos. 10 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Conrad L.Laage

11-BIRTHPLACE OF FATHER, (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Florence Phillips

13-BIRTHPLACE OF MOTHER, (State or Country), Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Conrad L. Laage

(Address) 2233 Wilkens Ave.

15- Filed JUL 4 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 2/23 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, probably due parturition

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORA (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Fallon M. D. (Coroner.)

7/3/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Johns Hopkins DATE OF BURIAL. July 6 1923

20-UNDERTAKER. George L. Schmidt ADDRESS 2101 Eutaw Ave.

Fully supplied. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Wueger ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77259 D77259

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospt ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Wueger

(a) RESIDENCE NO. 2203 W. Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick Wueger

6 DATE OF BIRTH (month, day, and year): July 6 1882

7 AGE — Years: 40 — Months: 11 — Days: 28 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Candy Store

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Louise Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Frederick Wueger

(Address) 2203 W. Pratt St.

15 Filed JUL 4 - 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7. 3 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1923, to June 2, 1923, that I last saw her alive on June 2, 1923, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Shock due to operation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Carcinoma of Uterus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7. 2. 23

Was there an autopsy? no

What test confirmed diagnosis? Laboratory findings

(Signed) Walter A. Cox, M. D.

7. 3, 1923 (Address) 571 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: July 6 1923

20 UNDERTAKER: George L. Schwab — ADDRESS: 916 Pratt St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77260
1-PLACE OF DEATH

CERTIFICATE OF DEATH. 74-001 D77260

REGISTERED No. C

CITY OF BALTIMORE (No. 312, W, BIDDLE, ST, St. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME JAMES JONES.

(Residence in Baltimore: No. 312. W, BIDDLE, St.: 43 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
MALE	COLORD	SINGLE

6-DATE OF BIRTH, UNKNOWN (Month) (Day), 1880 (Year)

7-AGE, about 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: LABORER
(b) General nature of industry, business, or establishment in which employed (or employer): General

9-BIRTHPLACE, (State or Country), BALTIMORE, CITY, Md.

PARENTS.

10-NAME OF FATHER, DONT KNOW,

11-BIRTHPLACE OF FATHER (State or Country). DONT KNOW,

12-MAIDEN NAME OF MOTHER DONT KNOW,

13-BIRTHPLACE OF MOTHER (State or Country), DONT KNOW,

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) MISS, HESTER TULL,

(Address) 312, W, BIDDLEm ST,

15-

Filed JUL 4 1923, 191.. ROBERT R. KRAETER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 3, (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

July 4, 1923, (Address) 2 E. Fayette

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, MT, AUBURN CEM, DATE OF BURIAL, 7,5, 19 23

20-UNDERTAKER Wand Eaton ADDRESS 516 Pa ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 D77261

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D77261

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No. ..... ST. 4 WARD)

2-FULL NAME Dora Wilbourn

(a) RESIDENCE No. 766 Vine ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant (Address) Bay View Hospital Baltimore, Md.

15

JUL 4 - 1923 ROBERT R. KRAMER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1923, to July 2, 1923

that I last saw h[illegible] alive on July 2, 1923

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of April 15, 23

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) N. F. Coombs M. D.

7/3/1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MT, AUBURN CEM, — DATE OF BURIAL: 7, 5 1923

20 UNDERTAKER: Hamel Easton — ADDRESS 916 Same

PRINT, WITH FADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

77262

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77262 CERTIFICATE OF DEATH. 44 D77262

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3835 Park Heights Ave. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia Morris Kemper.

(a) RESIDENCE. NO. 3835 Park Heights Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Kemper

6 DATE OF BIRTH (month, day, and year) May 5 1854.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Jacob Abramson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER L. Kaspales.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Julius Kemper

Address 109 N. Bolto St. Bon

15 FILED JUL 4 - 1923 ROBERT R. KRAMER

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1923, to July 3, 1923, that I last saw h[illegible] alive on July 3, 1923, and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of

Was there an autopsy? no Clinical

What test confirmed diagnosis?

(Signed) M. Cohen M.D. M. D.

[illegible] (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Sinai Cem

DATE OF BURIAL 7/5 1923

20 UNDERTAKER [illegible] & CO. FUNERAL DIRECTORS AND EMBALMERS

ADDRESS

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD.

Spec.—1-10-21—M&T—1500 Blks.

D77263 7 4 19

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 100-001 D77263

1 PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME David Varner

(a) RESIDENCE NO. Barlow ST., W. Va. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. David Varner

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer) Farming

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) W. Va.

PARENTS

10 NAME OF FATHER John Varner

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Dina Nottingham

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) W. Va.

14 Informant JOHNS HOPKINS HOSPITAL (Address) Reeds

15 Filed JUL 4 - 1923 19 ROBERT R. KRAMES Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3rd 1923

17

I HEREBY CERTIFY, That I attended deceased from June 26th, 1923, to July 3, 1923.

that I last saw him alive on July 3, 1923.

and that death occurred, on the date stated above, at 9 A.M. P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.

(duration) ..... yrs. ..... mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of June 27

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) John Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Barlow W Va — DATE OF BURIAL July 4, 1923

20 UNDERTAKER Joseph Abrens — ADDRESS 221 Bway

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

7264 [redacted]

HEALTH DEPARTMENT—CITY OF BALTIMORE

7264 [redacted]

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Combash

(a) Residence No. 916 Wilmer Alley St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	?

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1848

7-AGE 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ?

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (City or Town) Baltimore
(State or Country)

PARENTS.

10-NAME OF FATHER [illegible]

11-BIRTHPLACE OF FATHER (City or town) ?
(State or Country) [illegible]

12-MAIDEN NAME OF MOTHER [illegible]

13-BIRTHPLACE OF MOTHER (City or town) ?
(State or Country) [illegible]

14- (Informant) Municipal Hospital Records

(Address)

15- [illegible] BERT R. KRAUTER,
Burial Permit Clerk.

JUL 5 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 2, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 27 19 23 to July 2 19 23

that I last saw h[illegible] alive on July 2 19 23

and that death occurred, on the date stated above, at 2;15 P. M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. Feldman M. D

7-3- 19 23 Address Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
MT. AUBURN, CEM,	7, 5 ..., 19...
20-UNDERTAKER. David Easton	ADDRESS 916 Gwynns Ave

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77265 HEALTH DEPARTMENT—CITY OF BALTIMORE D77265

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3333 Edmondson St. WARD)

2-FULL NAME Josie Love

(a) RESIDENCE. No. 3333 Edmondson ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James R. Love

6 DATE OF BIRTH (month, day, and year) Jan. 22-1881

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
42	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant James R Love (Address) 3333 Edmondson

15 JUL 5 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1 1921 to July 4 1923 that I last saw h[illegible] alive on July 3 1921, and that death occurred, on the date stated above, at 3.30 a.m.

The CAUSE OF DEATH* was as follows: Tuberculosis of lungs

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) Irvin Eckenrode M. D.

July 5 1923 (Address) 74 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Easton Md July 7 1923

20 UNDERTAKER ADDRESS

Chas. E. Brandt 802 Madison

SHOULD be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77266 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D77266

56

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1004 Creek alley ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Naomi Hudson

(a) RESIDENCE. No. 1004 Creek alley WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. 11 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Colored	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 8" 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Leroy Hudson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Larretta Cornish

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Larretta Cornish
(Address) 1004 Creek alley

15 Filed , 19 .

JUL 5 - 1923

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5" 1923

17

I HEREBY CERTIFY, That I attended deceased from July 1" 1923 to July 3" 1923, that I last saw h alive on July 3" 1923 and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Convulsions,
Rickets

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. L. Shelton, M. D.

(Address) 203 N. Hanlon St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Ct	July 5 1923

20 UNDERTAKER S. L. Brown & Son ADDRESS 1858 Hanlon

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Every item of information is a PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1 D77267

CERTIFICATE OF DEATH.

183 D77267

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST., 27 WARD)

2-FULL NAME Samuel Chertkof

(a) RESIDENCE No Rogers & South Bend Ave. ST., ... WARD ..... (Mt. Washington)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 13 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Real Estate Office
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Bernard Chertkof

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Greenstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Bernard Chertkof
(Address) Rogers & South Bend Aves

15 Filed July 5 1923 GG Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to cut by
shot wound in chest

(duration) ..... yrs. Wks 4 hrs. mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Hennessy, M. D.
(Coroner.)

July 5, 1923 (Address) 29 E. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lebanon Cem. Carroll	July 5 1923

20 UNDERTAKER East Lewis, ADDRESS 1432 E. Balto

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77268

CERTIFICATE OF DEATH.

129 D77268

1-PLACE OF DEATH 1609 Registered No.

City of BALTIMORE: (No. 1609 Clifton Ave St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise R. Reimer

(a) Residence No. 1609 Clifton Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 21 1858

7-AGE. 55 yrs. 4 mos. 17 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Dressmaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Italy

PARENTS.

10-NAME OF FATHER, Anton Reimer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Josephine Kuffleth

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Marie Reimer

(Address) 1609 Clifton Ave

15- Filed JUL 5 - 1923 192 GG Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 4 1923

17- I HEREBY CERTIFY, That I attended deceased from 7-2-1923 to 7-4-1923

that I last saw her alive on 7-4-1923

and that death occurred, on the date stated above, at 4:30 A.M. on.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. 6 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? (Examination)

(Signed) Wm. Thos. Bryant M. D.

, 19 (Address) 1122 Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, July 7, 1923

20-UNDERTAKER, Joseph Syfer ADDRESS 1600 N. Howard St.

Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AFFIDAVIT

Spec—12-23-21—E.B.R.S.—400 Bks.

D77269 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164 D77269

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1846 N. Gay St St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Anna R. Quick

(a) Residence No. 1846 N. Gay St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of George Quick

6-DATE OF BIRTH (month, day and year) March 24 1843

7-AGE.	If LESS than 1 day,
80 yrs. 3 mos. 20 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS:

10-NAME OF FATHER, John J. Schone

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Bridget Cottrell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

11-(Informant) Catherine E. Hasseidel

(Address) 1846 N. Gay St

15-Filed ..... 192.. Registrar.

JUL 5 - 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 4 1923

17- I HEREBY CERTIFY, That I attended deceased from June 10 1923 to July 3 1923

that I last saw h. alive on July 3 1923

and that death occurred, on the date stated above, at 4A. m.

The CAUSE OF DEATH* was as follows:

Intermittent Fever

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. N. Morgan M. D.

5/5 1923 (Address) 14 E. Read St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Greenmount Cem.	July 6 1923

20-UNDERTAKER.	ADDRESS
Josias Syffer	16 W. Read St

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77270

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77270

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 S Monroe ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. West

(a) RESIDENCE No. 614 S Monroe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of (Est) Rebecca West

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Paving

(c) Name of employer United Ry & Elec Co

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John West
(Address) 614 S Monroe St

15 Filed JUL 5 1923 L.L.K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3. 1923

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1923, to July 3. 1923, that I last saw him alive on July 2, 1923, and that death occurred, on the date stated above, at 12:30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) 1 yrs. (?) mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) G E Burton, M. D.

7/4, 1923 (Address) 301 East Eros

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL July 5 1923

20 UNDERTAKER Harry H. Witzke — ADDRESS 1534 W Lombard St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77271

D77271

46

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 918 N. Castle ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma M. Stengel

(a) RESIDENCE NO. 918 N. Castle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. 10 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Louis J. Stengel

6 DATE OF BIRTH (month, day, and year): Aug 5th 71

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Philip Miskimon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Louis J. Stengel

(Address): 918 N. Castle

15 Filed JUL 5 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Stat'y Fee

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 3 1923

17 I HEREBY CERTIFY, That I attended deceased from June, 1922, to July 3, 1923, that I last saw her alive on July 3, 1923, and that death occurred, on the date stated above, at 5 25 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Cancer) of Uterus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion of Cancer

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis B. M. Krause M. D.

, 19 (Address) 5500 E. Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: 7/6 1923

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Aliceanna

INSTRUCTIONS should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77272

CERTIFICATE OF DEATH.

129 ✓ D77272

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3115 E Monument ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Gable

(a) RESIDENCE No. 3105 E Monument ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Color

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Gable

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: George Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Louise Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mr Gable

(Address) 3105 E monument st

15 Filed . 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 3 1923

17 I HEREBY CERTIFY, That I attended deceased from June 21 . 1923 . to July 3 . 1923

that I last saw h[illegible] alive on July 2 . 1923

and that death occurred, on the date stated above, at 4 A1 m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Richard S Leadbetter M. D.

. 19 (Address) 515 S Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemtry

DATE OF BURIAL: July 6 1923

20 UNDERTAKER: George Ruth

ADDRESS 1735 Harford ave

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be given as nearly as possible. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77273 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-001 D77273

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Pronounced dead at Johns Hopkins Hospital St., 27 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter M. Barrett

(Residence in Baltimore: No. 3440 Belair Rd. St.; yrs., 6 mos. ~~ds.~~)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	married

6-DATE OF BIRTH, Jan. 6/1863 (Month) (Day) (Year)

7-AGE. 60 yrs. 5 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Gen'l Work
(b) General nature of industry, business, or establishment in which employed (or employer): Standard Oil Co

9-BIRTHPLACE. (State or Country). Magnolia Del.

PARENTS

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country), "

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Millie M. Barrett

(Address) 3449 Belair Rd.

15- Filed JUL 5 1923 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 3/23 (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cerebral Hemorrhage

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Slight Hemaplegia about one yr. (Duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Collins M. D. (Coroner.)

7/4/23 192.... (Address) 508 E. North Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Pocomoke Md DATE OF BURIAL. 7/6 1923

20-UNDERTAKER. Philip Herrig ADDRESS 3016

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Information Should be Carefully Supplied. AGE should be stated EXACTLY. PHYSICIANS should

Spec.—8-24-14—M. & T.—2000 Bks.

D77274 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-081 D77274

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 533 W. Lafayette St.; 17 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Brown

(Residence in Baltimore: No. above St.; 67 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: Colored | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Widow

6-DATE OF BIRTH, March 10 (Month) (Day), 1856 (Year)

7-AGE: 67 yrs. 4 mos. 3 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work:
(b) General nature of industry, business, or establishment in which employed (or employer): Laundress

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Preston Jr

(Address) 533 Lafayette Ave

15- JUL 5 - 1923, 19..

ROBERT P. KRAUTER, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 4th (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 1923, to July 4th 1923, that I saw h[illegible] alive on June 30 1923, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Contributory Diabetes

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Myocarditis Chronic

(Duration) yrs. mos. ds.

(Signed) J. D. Lobeck M. D.

7-5-, 1923 (Address) 211 N. Gamble

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem. DATE OF BURIAL, 7-7-, 1923

20-UNDERTAKER, George T. A. Gibson ADDRESS 513 Fairmount Ave

IMPORTANT.—CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77275

CERTIFICATE OF DEATH.

90 D77275

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 4245 Greenmount Ave. St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert E. Prince

(Residence in Baltimore: No. 4245 Greenmount Ave. St., 8 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	married

6-DATE OF BIRTH. June 15/1859, 1..... (Month) (Day) (Year)

7-AGE. 64 yrs. 0 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Photographer
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Winchester, Va.

PARENTS.

10-NAME OF FATHER, Harry Prince

11-BIRTHPLACE OF FATHER, (State or Country) Holland

12-MAIDEN NAME OF MOTHER, Agnes Rieketts

13-BIRTHPLACE OF MOTHER, (State or Country) Warrenton Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Prince

(Address) 4245 Greenmount Ave.

15. JUL 5 - 1923

Filed ..... 192.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 3/23, 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insuffiency--a-
Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Rt. Hemoplegia- 8 to 10 yrs ago

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S H Powers M. D. (Coroner)

7/4/23 (Address) 508 E Fayette

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park DATE OF BURIAL. July 6 1923

20-UNDERTAKER. Mr Cook ADDRESS 502 E North

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(Shields)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77276

D77276

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1936 W Pratt ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Shields

(a) RESIDENCE NO. 1936 W Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John L

6 DATE OF BIRTH (month, day, and year): Sept 3 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Henry Corduay

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary J. Corbit

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Alice Dysart

(Address): 1936 W Pratt St

15 Filed: JUL 5 - 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 4 1923

17

I HEREBY CERTIFY, That I attended deceased from June 19, 1923, to July 4, 1923,

that I last saw h alive on July 4, 1923

and that death occurred, on the date stated above, at 8-30 P m.

The CAUSE OF DEATH* was as follows:

1 Endocarditis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Harwood Kahn, M. D.

7/5, 1923 (Address) 727 W Read

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: July 7 1923

20 UNDERTAKER: Wm Cole

ADDRESS: 502 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Stiffler 37 So. Fulton.

HEALTH DEPARTMENT—CITY OF BALTIMORE D77277.

CERTIFICATE OF DEATH.

D77277

164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 388 E. 20th St., 12 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Dorsey

(a) RESIDENCE NO. 388 E 20th St., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	widow

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Francis H.

6 DATE OF BIRTH (month, day, and year) Feb. 23 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	93			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William H. Bremaver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Charity Milligan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Jennie L Nelson

(Address) 311 E 20th St City

15 Filed JUL 5 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1923

17

I HEREBY CERTIFY, That I attended deceased from 1916, 19 , to July 4, 1923, that I last saw her alive on July 4, 1923, and that death occurred, on the date stated above, at 5 4 m.

The CAUSE OF DEATH* was as follows:

Old age

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas A Schaefer, M. D.

, 19 (Address) 53 S Fulton Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 6 1923

20 UNDERTAKER Wm Cook & Son ADDRESS E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77278 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 5 D77278

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital St. 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Meek Starr.

(a) RESIDENCE No. York, South Carolina ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) Feb. 19, 1859.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64.	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina.

PARENTS

10 NAME OF FATHER John Starr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Carolina.

12 MAIDEN NAME OF MOTHER Mary Sandifer.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Carolina.

14 Informant Mary Sandifer (Address)

15 JUL 5 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/5/1923

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1923, to July 5, 1923, that I last saw him alive on July 5, 1923, and that death occurred, on the date stated above, at 6.50 A. m.

The CAUSE OF DEATH* was as follows:

Pyelitis.

(duration) 0 yrs. mos. 24 da.

CONTRIBUTORY (Secondary) Bronchopneumonia, 7 days.

Diabetes Mellitus (duration) 7 yrs. mos. da.

18 Where was disease contracted if not at place of death? York, South Carolina.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Examination of urine.

(Signed) J. W. Turner, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Hill S.C.	July 5th 1923
20 UNDERTAKER	ADDRESS
Henry H. Jenkins Sons	Orchard & Nicollet Sts

INSTRUCTIONS—THIS RECORD. Every item of this CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77279

CERTIFICATE OF DEATH.

5 D77279

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital 2 St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Drake

(a) Residence No. 246 S. Durham St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 10 1887

7-AGE. 36 yrs. — mos. 24 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Poland

PARENTS.

10-NAME OF FATHER, [illegible]

11-BIRTHPLACE OF FATHER (city or town) (State or Country), [illegible]

12-MAIDEN NAME OF MOTHER, [illegible]

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), [illegible]

14- (Informant) Municipal Hospital Records

(Address)

15- Filed JUL 5 - 1923 [signature] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 4 1923

17- I HEREBY CERTIFY, That I attended deceased from June 7, 1923 to July 4 1923 that I last saw h[illegible] alive on July 4, 1923 and that death occurred, on the date stated above, at 4 30 p.m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

? (Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. Friedenwald M. D

(Address) Municipal Hospital 7-4 1923

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Rosary	July 6 1923
20-UNDERTAKER.	ADDRESS
John A. Weber	1803 Bank St

In plain terms, so that it may be properly classified. EXACTLY: PHYSICIANS should state CAUSE OF DEATH instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Spec.—1-10-21—M&T—1500 Bks.

D77280

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 D77280

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1627 Eutaw Place 14 WARD)

2-FULL NAME Margaret Helen Richardson

(a) RESIDENCE NO. 1627 Eutaw Place ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Harry D. Richardson

6 DATE OF BIRTH (month, day, and year): Aug 15 1866.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56.	10	19.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Talbot Co Md

PARENTS

10 NAME OF FATHER: Hugh Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: M. Helen Tripp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Harry D. Richardson

(Address): 1627 Eutaw Place

15 Filed: JUL 5 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 4 1923

17

I HEREBY CERTIFY, That I attended deceased from January, 1923, to July, 1923.

that I last saw her alive on July 4th, 1923

and that death occurred, on the date stated above, at 12 30 a.m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

1 hour (duration)

CONTRIBUTORY (Secondary): Arteriosclerosis, high tension

several (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr Chas DeGaa, M. D.

, 19 (Address) 1702 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July 6 1923

20 UNDERTAKER	ADDRESS
John O. Mitchell	1201 W Fayette

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D77281 HEALTH DEPARTMENT—CITY OF BALTIMORE D77281

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2210 Linden Ave St., 14 Ward) Registered No. 74-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Klein

(a) Residence No. 2210 Linden Ave St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 1, 1859

7-AGE, 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). New York City N.Y.

PARENTS.

10-NAME OF FATHER Christopher Klein

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER Elizabeth Schlegel

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany.

14- (Informant) Adolph Klein
(Address) 2210 Linden Ave

15- Filed JUL 5 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 4 1923.

17- I HEREBY CERTIFY, That I attended deceased from January, 1922, to July, 1923, that I last saw h[illegible] alive on July 4, 1923, and that death occurred, on the date stated above, at 29 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis + angina pectoris

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Frederick Lentz M. D.

7/4, 1923 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge DATE OF BURIAL, July 6, 1923

20-UNDERTAKER. John C Mulcahey ADDRESS 720 W Fayette

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D77282

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12581081

D77282

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2913 Guilford St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Vickers Hartzog.

(a) Residence No. 2913 Guilford ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Hartz

6-DATE OF BIRTH (month, day and year) Aug 25 1850

7-AGE 72 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Westerstown Md

PARENTS.

10-NAME OF FATHER, Geo Vickers

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary Mansfield

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) William Hartzog Vickers

(Address) 2913 Guilford ave

15- Filed JUL 5 - 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 4 1923

17- I HEREBY CERTIFY, That I attended deceased from 6/29 1922, to 7/4, 1923, that I last saw h. alive on 7/4, 1923 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Pernicious anaemia

(Duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Prostatectomy

(Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab. findings

(Signed) [illegible] M. D.

7/5, 1923 (Address) 1008 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park — DATE OF BURIAL, July 6, 1923

20-UNDERTAKER, John A Mitchell — ADDRESS 1201 W Fayette

In plain terms, so that it may be properly classified. CAUSE OF DEATH instructions on back of certificates. See

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77283 CERTIFICATE OF DEATH. X 113 D77283

1-PLACE OF DEATH Registered No.

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Reed

(a) Residence No. Monkton Md St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb. 1923

7-AGE. 5 months
.....yrs. .....mos. .....ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Monkton Md (State or Country),

PARENTS.

10-NAME OF FATHER, James Reed.

11-BIRTHPLACE OF FATHER (city or town) Del. (State or Country),

12-MAIDEN NAME OF MOTHER, Lillian Miller

13-BIRTHPLACE OF MOTHER (city or town) Balto Md. (State or Country),

14-

(Informant) Lillian Miller

(Address) Balt. Md.

15-Filed JUL 5 - 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 4 1923

17- I HEREBY CERTIFY, That I attended deceased from June 23 1923 to July 4 1923 that I last saw h alive on June 23 1923 and that death occurred, on the date stated above, at 3.30 A.M.

The CAUSE OF DEATH* was as follows:

Marasmus

Duration Unknown

CONTRIBUTORY (Secondary) Cardiac Failure

24 hrs. (Duration) .....yrs. .....mos. .....ds.

18-Where was disease contracted if not at place of death? Monkton Md. Surgical Pavilion

Did an operation precede death? Yes Date of 7/3/23 & Sept 24

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) K. W. Goldberg, M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, JOHNS HOPKINS HOSPITAL | DATE OF BURIAL, ..., 19....

20-UNDERTAKER. | ADDRESS

Commissioner of Health. JUL 5 - 1923

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Probably a Gastro Enteritis

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77284 — CERTIFICATE OF DEATH. — D77284

100-00

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Pate

(a) RESIDENCE NO. 125 N. Greene ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1857

7 AGE: Years 66. Months Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): North Carolina Unknown

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do

14 Informant (Address): Bay View Hospital Balto, Md.

15 Filed JUL 5 - 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 2, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 4 19 22 to July 2 19 23

that I last saw him alive on July 2 19 23 and that death occurred, on the date stated above, at 4.45 p.m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Chronic)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) N. F. Edmunds M.D.

7/3/1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JUL 5 - 1923

Commissioner of Health

JUL 5 - 1923

Instructions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77285

CERTIFICATE OF DEATH.

129 D77285

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia Griffin

(a) Residence No. 26 Weber St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Black	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1874

7-AGE. 49 yrs. mos. ds. If LESS than 1 day, hrs. or. min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Arnston Griffin

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Eliza Bellon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Municipal Hospital Records

(Address)

15- FILED JUL 5 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

0519

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 2, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 16 19 23 to July 2 19 23.

that I last saw h. er alive on July 2 19 23.

and that death occurred, on the date stated above, at 2:15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 2 yrs (history) mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A Goldstein M. D.

7-3-19 23 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND. DATE OF BURIAL, JUL 5-1923

20-UNDERTAKER. Commissioner Health ADDRESS

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 31 D77286

1-PLACE OF DEATH D77286 REGISTERED NO.

CITY OF BALTIMORE: (No. 313-N-Green-St. ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ROSE EMMA GIBNEY

(a) RESIDENCE NO. 313-N-Green-St. ST., 4 WARD (Resident)
(Usual place of abode)
Length of residence in city or town where death occurred 24 yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? 24 yrs. 3 mos. 6 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) March-27-1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Christopher S. Gibney

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Raycob

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. Frank E. Gibney (brother)
(Address) 313-N-Green-St., City.

15 Filed JUL 5 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1923

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1923 to July 3, 1923.
That I last saw h[illegible] alive on July 2, 1923
and that death occurred, on the date stated above, at 3.00 P m.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Tubercle bacilli

(Signed) Ernest Dr. Palen M. D.

7/3, 1923 (Address) 900 N. Mount St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
NEW CATHEDRAL CEMETERY	July-5-23

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM T. MOOGER, Successor) ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements. AGE should be stated EXACTLY. Use only authorized abbreviations. Avoid use of ditto marks. Fill all blanks. Write plainly. Supplies. AGE
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77287

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 129 D77287

1-PLACE OF DEATH Mrs Mair's Hospital

CITY OF BALTIMORE: (No. 723 St. Paul St. ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Gabriel Whitehead

(a) RESIDENCE NO. 723 St. Paul ST., 11 WARD Williamsport Pa.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? 39 yrs. 11 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mariam Whitehead

6 DATE OF BIRTH (month, day, and year): Aug-3-1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Auto. Supplies

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): South Williamsport Penna

PARENTS

10 NAME OF FATHER: Harvey H. Whitehead

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bradford N.Y.

12 MAIDEN NAME OF MOTHER: Laura Gabriel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Northumberland " "

14 Informant: Mrs L. M. Hyman (Sec'y)
(Address) 330-E-3-St Williamsport Pa

15 Filed JUL 5 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1923, to July-4, 1923, that I last saw him live on July 4, 1923, and that death occurred, on the date stated above, at 2:60 A.m.

The CAUSE OF DEATH* was as follows:

Hypertension
Arteriosclerosis
Chronic nephritis.

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leslie M Gay, M. D.

, 19 (Address) 1014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Williamsport Pa.

DATE OF BURIAL: July-5 1923

20 UNDERTAKER: STEWART & HOWEN COMPANY

ADDRESS 108 W. NORTH AVE

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

163024 9 04 A.M. D77288

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 49 ✓ D77288

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 7 WARD)

2-FULL NAME Mr. Andrew A. Patterson.

(a) RESIDENCE NO. Jamaica, Port Antonio ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~Simultaneous~~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) May 4, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Planter.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Jamaica.

PARENTS

10 NAME OF FATHER James Patterson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jamaica.

12 MAIDEN NAME OF MOTHER Margaret Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jamaica.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 JUL 5 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1923, to July 5, 1923, that I last saw him alive on July 5, 1923, and that death occurred, on the date stated above, at 9 04 A.m.

The CAUSE OF DEATH* was as follows: Carcinoma of Bladder

(duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pulmonical abscess

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Jamaica

Did an operation precede death? yes Date of 4/21/23

Was there an autopsy? yes Autopsy

What test confirmed diagnosis?

(Signed) Eugene C. Hand M. D.

, 19 (Address) John Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Jamaica Port antonia — DATE OF BURIAL: July 7 1923

UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Busy

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77289

CERTIFICATE OF DEATH.

129 D77289

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto Gen Hos ST., 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J. Taylor

(a) RESIDENCE NO. 723 Glenwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 9 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dora Taylor

6 DATE OF BIRTH (month, day, and year) Sept 29 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER James Taylor

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Julia Whelan

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Chas J. Taylor Jr

(Address) 723 Glenwood Ave Govans

15 JUL 5 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1923

17

I HEREBY CERTIFY, That I attended deceased from July 2, 1923, to July 4, 1923,

that I last saw him alive on July 4, 1923,

and that death occurred, on the date stated above, at 1.20 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis & Nephritis

& Cirrhosis of Liver,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) indefinitely. yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Henry C Warlick, M. D.

, 19 (Address) South Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem DATE OF BURIAL July 7 1923

20 UNDERTAKER Wm J Pickett & Son ADDRESS North & Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state AGE if literally supplied. AGE

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non Alcoholic.
Chronic Interstitial Nephritis

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77290

CERTIFICATE OF DEATH. 179

REGISTERED No. D77290

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3409 Leverton Ave ST., N WARD)

2-FULL NAME Bayard Heisel Heiry Jr

(a) RESIDENCE No. 3409 Leverton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life time yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Bayard H Heiry

11 BIRTHPLACE OF FATHER (city or town) St Georges (State or country) Del

12 MAIDEN NAME OF MOTHER Laura E. Linderman

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Mrs Emma Linderman

(Address) 3409 Leverton Ave

15 FILED JUL 5 - 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

CORONER FOR BALTIMORE CITY-EASTERN DISTRICT

July 4/23

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1923

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1923, to July 5, 1923, that I saw him alive on July 5, 1923, and that death occurred, on the date stated above, at 12.10 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Uremic Convulsions

(duration) 4 yrs. 3 mos 3 ds.

CONTRIBUTORY (Secondary) Scald Face & Body

(duration) yrs. mos. 18 ds.

Where there was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wright Fuller, M.D.

July 7 1923 (Address) 3323 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem	July 6 1923

20 UNDERTAKER H. Allen Fuller

ADDRESS 2902 Garrison Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. **Examples:** *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia;* *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accidental - child ran into mother who was carrying a pot of scalding water

Spec.—1-10-21—M&T—1500 Bks.

D77291 HEALTH DEPARTMENT—CITY OF BALTIMORE D77291

CERTIFICATE OF DEATH.

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 913 S. Linwood. Ave. WARD) 1

2-FULL NAME William W. Spence.

(a) RESIDENCE No. 913 S. Linwood Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 18-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	1	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer) (None)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER K. L. Spence

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Meta Sinclair

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant K. L. Spence

(Address) Baltimore Md

15 JUL 6 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1923

17 I HEREBY CERTIFY, That I attended deceased from June 30th, 1923, to July 5th, 1923, that I last saw him alive on July 5th, 1923, and that death occurred, on the date stated above, at 9 00 A. m.

The CAUSE OF DEATH* was as follows:

Measles - D

Whooping Cough (Pertussis)

Pertussis - (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia & Meningitis (Septic) (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? — — — 7 "

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Philibert Antignani M. D.

7-5-1923 (Address) 2942 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	July 6 1923
20 UNDERTAKER	ADDRESS
H. Gander & Sons	1710 Flut St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77292

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001 D77292

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST. 16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Johnson -

(a) RESIDENCE NO. 1324 Mosher ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. — mos. ds. How long in U. S., if of foreign birth? —yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored -

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Feb 20 - 1912 Lithonia

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
11	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School-girl -

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Lem Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md -

12 MAIDEN NAME OF MOTHER: Maggie Conatie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md -

14 Informant: University Hospital records (Address)

15 JUL 6 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5 1923

17

I HEREBY CERTIFY, That I attended deceased from 6/27, 1923, to 7/5, 1923, that I last saw h-r alive on 7/4, 1923, and that death occurred, on the date stated above, at 4:15 a.m.

The CAUSE OF DEATH* was as follows:

Typhoid fever.

(duration) —yrs. mos 14 ds.

CONTRIBUTORY (Secondary): Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? yes.

What test confirmed diagnosis? Laboratory. Autopsy.

(Signed) B. M. Baker, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: 7/6 1923

20 UNDERTAKER: Samuel T. Hensley

ADDRESS 1378 N. Bdle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Hanff)

Spec.—1-10-21—M&T—1500 Bks.

D77293

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D77293

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bay View Hospital 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Otto Hauff.

(a) RESIDENCE No. 1416 Eastern ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Hauff

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unkn.

11 BIRTHPLACE OF FATHER (city or town) Germ. (State or country)

12 MAIDEN NAME OF MOTHER Unkn.

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Katie Hauff.

(Address) 1416 Eastern ave.

15 Filed JUL 6 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1923, to July 3, 1923.

That I last saw him alive on July 3, 1923

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Tubercular Pneumonia

Unkn (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocard. Insuffic.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) H. Hedemann, M. D.

7/4, 1923 (Address) Boyview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery. DATE OF BURIAL July 6 1923

20 UNDERTAKER Geo. J. Ruth ADDRESS 1735 Hanford ave.

CAUSE should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

(Grover Bernard Fisher)

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

D77294

D77294

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin St. 23 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grover Bernard Fisher

(Residence in Baltimore: No. 1202 Light St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, June 26 (Month) (Day) 23 (Year)

7-AGE, yrs. mos. 9 ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Grover C Fisher

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Hallie Gale

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grover C Fisher

(Address) 1202 Light St.

15-

Filed JUL 6 1923

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 5th (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 26 23 191 , to July 5th 1923 , that I saw him alive on July 5th 1923 , and that death occurred, on the date stated above, at 10.30 a.m.

The CAUSE OF DEATH* was as follows:

Premature
Premature birth

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(Duration) yrs. mos. ds.

(Signed) Frank D Kolb M. D.

July 6 1923 191. (Address) 1203 Light St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 9 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cem

DATE OF BURIAL, 7 6, 1923

20-UNDERTAKER J F Stakey & Sons

ADDRESS 918 Light St

IMPORTANT. See instructions on back of certificate. Information required by law; and that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—1-10-21—M&T—1500 Bks.

Time of burial extended to Saturday July 7/23

D77295

HEALTH DEPARTMENT—CITY OF BALTIMORE D77295

CERTIFICATE OF DEATH.

Frederick Stumpf Asst Com,

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1144 N. Stricker ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edna Hortense Ford

(a) RESIDENCE NO. 1144 N. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 30-1920

7 AGE: 3 Years 1 Months 5 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Joseph S. Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Jessie Shields

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Jessie Shields Ford

(Address): 1144 N. Stricker St

Filed JUL 6 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923 to July 5, 1923, that I last saw h alive on July 5, 1923, and that death occurred, on the date stated above, at 10-30 A.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Whooping cough

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. McCausland, M. D.

, 19 (Address) 2410 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: July 6th 1923

20 UNDERTAKER: Joseph a Farrell — ADDRESS: 2317 Division

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77296

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77296

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH 1838 McHenry St.,

CITY OF BALTIMORE: (No. " " ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris C. Bach.

(a) RESIDENCE No. 1838 McHenry St., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 11? 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	I	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.,

PARENTS

10 NAME OF FATHER James Bach

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.,

12 MAIDEN NAME OF MOTHER Catherine Hackman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.,

14 Informant James Bach
(Address) 1838 McHenry St

Filed JUL 6 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/3 1923

17 I HEREBY CERTIFY, That I attended deceased from 6/28, 1923, to 7/3, 1923, that I last saw h[illegible] alive on 7/3, 1923, and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Abscess

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical & X-Ray

(Signed) James N. Kerr M. D.

7/5, 1923 (Address) 1729 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bonnie Brae — DATE OF BURIAL July 6 1923

20 UNDERTAKER Harry H. Nitzke — ADDRESS 1531 E. Monument St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77297 HEALTH DEPARTMENT—CITY OF BALTIMORE D77297

CERTIFICATE OF DEATH. 183-001

1-PLACE OF DEATH St Agnes Hospital Registered No. C.....

City of BALTIMORE: (No. ..... Ward)

2-FULL NAME..... Herbert H. Plate

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 111 Union Ave St.; yrs. 5/12 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. April (Month) 13 (Day) 1900 (Year)

7-AGE. 12 yrs. 2 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Maryland

PARENTS.

10-NAME OF FATHER. William Plate

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Emma Pole

13-BIRTHPLACE OF MOTHER, (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Plate

(Address) 111 Union Ave

JUL 6 - 1923 Registrar Hamm

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 4 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Gun Shot Accident

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Lock Jaw

(Duration) ....yrs. ....mos. ....ds.

(Signed) Geo Edw Pfahl (Coroner)

July 23 (Address) 4376 Reisterstown Rd

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Loudon Park DATE OF BURIAL. July 7 1923

20-UNDERTAKER. Harry W. Witzke ADDRESS 3814 Woodland Ave

may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D77298 HEALTH DEPARTMENT—CITY OF BALTIMORE D77298

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of BALTIMORE: (No. Univ Hospital St. Ward) 19 17 Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Harry Graham

(Residence in Baltimore: No. 370 N Arlington St. St.; 16 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. colored

5-Single, Married, Widowed or Divorced, (Write the word.) Single

6-DATE OF BIRTH. Sept (Month) 15 (Day) 1892 (Year)

7-AGE. 30 yrs. 9 mos. 17 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laber
(b) General nature of industry, business, or establishment in which employed (or employer):

040

9-BIRTHPLACE, (State or Country). Calvert Co Md

PARENTS.

10-NAME OF FATHER. John Graham

11-BIRTHPLACE OF FATHER, (State or Couutry). Md

12-MAIDEN NAME OF MOTHER. Mary Gray

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) arthur Graham

(Address) 870 Vine St

15- Filed JUL 6 - 1923 19.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 25 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon, and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Gun Shot Wounds Homicide

(Duration) yrs. mos. 8 hr. ds.

CONTRIBUTORY (Secondary) Hardening of Lungs

(Duration) yrs. mos. ds.

(Signed) G C Radcliffe M. D. Coroner.

July 25 1923 (Address) 1753 N Gay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Calvert Md Locust Run DATE OF BURIAL. July 8 1923

20-UNDERTAKER. P C Goods ADDRESS 1405 McElderry

IT IS VERY IMPORTANT. See Instructions on back of certificate. Exact statement of OCCUPATION may be properly classified. PHYSICIANS should

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77299

100-001

D77299

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1185 5th ST., 26 WARD)

2-FULL NAME Joseph Cerra

(a) RESIDENCE NO. 1185 5th ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 18-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER Sam Cerra

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Angelina Frotto

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Sam Cerra (Address) 1185 5th

15 Filed JUL 6-1923, 19 EK Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 4, 1923, to July 5, 1923, that I last saw him alive on July 5, 1923, and that death occurred, on the date stated above at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

aon

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Maxwell L Mayer M. D.

7/5, 1923 (Address) 315 E Balt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem

DATE OF BURIAL July 7 1923

20 UNDERTAKER John Sellier

ADDRESS 2008 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILMED

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77300

CERTIFICATE OF DEATH.

54-001 D77300

1-PLACE OF DEATH — WEINKAM

CITY OF BALTIMORE: (No. 913 W Mulberry ST., 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew M. D'Emfaine

(a) RESIDENCE No. 913 W Mulberry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3-17-1873

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
50	3	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman in Tin Shops
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B&O

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER John D'Emfaine

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER C. Mello

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Mrs M. D'Emfaine
(Address) 913 W Mulberry St

15 Filed ..... 192 ....., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Coroner, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) A K Seigel M. D.
(Coroner.)

7-6 1923 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL
Loudon Park Cemetery July 6 1923

20 UNDERTAKER — ADDRESS
John J Conaty 901 Hollins St

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA... should state ... be properly classified. ... PHYSICIANS ... in plain terms, so that it may be ...

S. A. F. ... O. D. A. K.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77301

CERTIFICATE OF DEATH.

7-109 D77301

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 515 Somerset ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Sarah Thomas

(a) RESIDENCE. No. 515 Somerset ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colrd	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of Industry, business, or establishment in which employed (or employer) House Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Moses Wiglin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jorden Thomas
(Address) 5-15 Lemmon-st

15 Filed JUL 6 - 1923, 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-4- 1923

17 I HEREBY CERTIFY, That I attended deceased from 6-30-, 1923, to 7-4-, 1923, that I last saw h.[illegible] alive on 7-3-, 1923, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. H. Haggill, M. D.

7-5-, 1923 (Address) 611-N-Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Windsor Shade Va	July 6 1923

20 UNDERTAKER Mrs Robert A Ellis ADDRESS 1725 Division

MAY be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

164584 12 30 A. M. D77302

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 ✓ D77302

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... St., 12 WARD)

2-FULL NAME Rosewale Brown

(a) RESIDENCE NO. 417 E. 23rd. St ~~St.~~ ~~City~~

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 3, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	1	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Joseph Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mamie Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUL 6 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3, 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1923 to July 3, 1923 that I last saw h alive on July 3, 1923, and that death occurred, on the date stated above, at 12 30 A.m.

The CAUSE OF DEATH* was as follows:

Miliary tuberculosis

(duration) yrs 2½ mos ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of X

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray

(Signed) A. A. Medd, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laural Cemetery	July 6 1923
20 UNDERTAKER Mrs Robert A Elliott	ADDRESS 1725 Ashland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77303

CERTIFICATE OF DEATH.

D77303

REGISTERED NO. 74001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen Hosp. X 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Rosalie Blakeley

(a) RESIDENCE NO. 507 Walker Ave Govans WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of H. D. Blakeley

6 DATE OF BIRTH (month, day, and year) May 13, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	62	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ellicott City, Md.
(State or country)

PARENTS

10 NAME OF FATHER Allen Thomas Fort

11 BIRTHPLACE OF FATHER (city or town) Ellicott City
(State or country) Md.

12 MAIDEN NAME OF MOTHER Cordelia Clarke.

13 BIRTHPLACE OF MOTHER (city or town) Fredricksburg,
(State or country) Virginia

14 Informant Self.
(Address)

15 Filed ..... 19 Registrar

JUL 6 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-4-23

17 I HEREBY CERTIFY, That I attended deceased from 7-2-23 19 , to 7-4-23 19 ,

that I last saw h alive on 7-4-23, 19 ,

and that death occurred, on the date stated above, at .... m.

The CAUSE OF DEATH* was as follows:

Cholycystitis. Cholylithiasis

H.R.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Ly. Hemiplegia. Nephritis chr.

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 7-3-23

Was there an autopsy? no

What test confirmed diagnosis? Clinical Sign.

(Signed) John A Tompkins, M. D.

, 19 (Address) Md Gen Hosp X,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem DATE OF BURIAL July 7 1923

20 UNDERTAKER Wm J Tickner & Sons ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 4 1500 Bks.

D77304

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77304

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2003 Ridgewood ave ST., 15 WARD)

REGISTERED NO. 573

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jane Fee

(a) RESIDENCE NO. 2003 Ridgewood ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): 5/15/1865

7 AGE: Years 58 | Months 1 | Days 17 | If LESS than 1 day hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Pat Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Anna M. Sykes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Wm. Fee

(Address): 2003 Ridgewood ave

15 JUL 6 - 1923

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-2-1923

17

I HEREBY CERTIFY, That I attended deceased from June 29, 1923, to July 4th, 1923, that I last saw her alive on July 2, 1923, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Multiple Neuritis?

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paresis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at above address

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas A Hatterloff M. D.

, 19 (Address) 1807 N Howard ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ridge Cemetery Private — DATE OF BURIAL: 7/6/23, 19

20 UNDERTAKER: George D. Ruth — ADDRESS: 1735 Harford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77305

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168 D77305

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 504 So. East ave 1 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Minnie J. Weber

(Residence in Baltimore: No. 504 So. East ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

6-DATE OF BIRTH. Dec 8th 1884
(Month) (Day) (Year)

7-AGE. 38 yrs. 7 mos. 26 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md

PARENTS.

10-NAME OF FATHER. John Beyer

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) August N. Weber

(Address) 504 So. East ave

15-

Filed JUL 6 - 1923 GG Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 4 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hanging Self
Strangulation

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) —

(Duration).....yrs.....mos.....ds.

(Signed) Thos. B. Norton M. D.
(Coroner)

July 7 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Balto. Md

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Oaklawn	July 7 1923
20-UNDERTAKER. Gickler & Gickler	ADDRESS 1739 Eager

is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D77306 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

678 D77306

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. S/S City of Annapolis Pier 6 ST. Light St. WARD wharf.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Christian. (C).

(a) RESIDENCE NO. 1713 Orleans ST. St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) April 28, 1897.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	2	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore.
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Yorktown Va.

PARENTS

10 NAME OF FATHER James Christian. (C)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Mary Harrod. (C).

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant James M. Christian. (C). (brother) (Address) 1713 Orleans St.

15 Filed JUL 6 - 1923 G.G. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy.

Acute dilatation of the heart.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto Reinhardt, M. D.
July 6, 1923. (Address) 1014 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL York town Va

DATE OF BURIAL July 7 1923

UNDERTAKER Edward Bryon

ADDRESS 631 Orleans St

IMPORTANT. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D77307 HEALTH DEPARTMENT—CITY OF BALTIMORE D77307

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 S. Bouldin St. ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Karl Zorn.

(a) RESIDENCE NO. 607 S. Bouldin St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? 42 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kunigunda Zorn

6 DATE OF BIRTH (month, day, and year) Feb. 2 - 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	5	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Mason

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Zorn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea Handel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Kunigunda Zorn

(Address) 607 S. Bouldin St

15 JUL 6 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1923 to July 5, 1923, that I last saw h— alive on July 5, 1923, and that death occurred, on the date stated above, at 1.50 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Gastric)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lucien B. Mc Knaus, M. D.

, 19 (Address) 2500 E. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	July 7 1923.
20 UNDERTAKER Lilly and Zeile	ADDRESS 403 S. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77308

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

117 D77308

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md. Gen. Hosp. (St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Law

(a) RESIDENCE NO. 9 North 11 St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 4 - 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
	11	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attended School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Martin D. Law.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Hattie Moore.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Martin D. Law (Address) 9 N. 11th St.

15 Filed . 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-5-1923

17 I HEREBY CERTIFY, That I attended deceased from 7-2-23 to 7-5-23, that I last saw him alive on 7-5-1923, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix.

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Toxemia. Acute Appendicitis

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? Yes Date of 7-2-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) John A. Tompkins M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. DATE OF BURIAL: July 7 1923.

20 UNDERTAKER: Lilly & Zeiler ADDRESS: 403 S Wolfe St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Bks.

16H 819

15 AD 7309

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77309

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 2

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ... ST., ... WARD)

2-FULL NAME Mary Massick

(a) RESIDENCE NO. 202 S. Chester St. ST., ... WARD ...

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. unknown mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Massick (husb).

6 DATE OF BIRTH (month, day, and year) Aug 15- 1883.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39 11	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife.

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) Baltimore (State or country) md.

PARENTS

10 NAME OF FATHER Simon Finn

11 BIRTHPLACE OF FATHER (city or town) — (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Mary O'Neil

13 BIRTHPLACE OF MOTHER (city or town) — (State or country) Ireland.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed ..., 19 ...

ROBERT P. KRAUTER, Undertaker, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1923.

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923. to July 5 1923. that I last saw her alive on July 5 1923, and that death occurred, on the date stated above, at 1.15 A.m.

The CAUSE OF DEATH* was as follows:

Hypertension; Chronic Nephritis; Uremic coma.

(duration) ? yrs. ? mos ? ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? B.P., Urine; Blood

(Signed) Chas. R. Bagg, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. DATE OF BURIAL July 7 1923

20 UNDERTAKER Lilly & Zeiler ADDRESS 403 S. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D77310

REGISTERED NO. D77310

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Wolfe

(a) RESIDENCE NO. 837 Holkins St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/30/23

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	2½	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Harry Matthews

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Nellie Wolfe

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant W.W. Gray
(Address) Johns Hopkins Hosp.

15 Filed JUL 6 - 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1923

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1923, to July 3, 1923, that I last saw h alive on July 3, 1923, and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos 2½ ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) W.W. Gray, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL JUL 5-1923

20 UNDERTAKER — ADDRESS

Commissioner Health.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77311

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77311

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2932 Guilford ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Girardin

(a) RESIDENCE NO. 2932 Guilford ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widow

5a If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) WIFE of Emil Girardin

6 DATE OF BIRTH (month, day, and year) July 6/49

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Leonardtown Md.

PARENTS

10 NAME OF FATHER Lyon

11 BIRTHPLACE OF FATHER (city or town) (State or country) dont know

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) dont know

14 Informant (Address) John B Girardin 2932 Guilford Apt

15 Filed JUL 6 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1923

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1923, to July 6, 1923, that I last saw her alive on July 5, 1923, and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral degeneration

Contributed by fracture of femur

(duration) 2 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? visual

(Signed) H E Krupt M. D.

July 6, 1923 (Address) 1102 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cemetery DATE OF BURIAL July 9 1923

20 UNDERTAKER W B Cook ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS should state TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy." "Collapse." "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy." "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Typed on carpet - 2 yrs ago.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77312

CERTIFICATE OF DEATH.

D77312

31

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 1636 N. Fulton Ave ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel M. Coburn

(a) RESIDENCE NO. 1636 N. Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie E.

6 DATE OF BIRTH (month, day, and year) June 22 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cheeriu Pa
(State or country)

PARENTS

10 NAME OF FATHER Hiram Le Coburn

11 BIRTHPLACE OF FATHER (city or town) Pa.
(State or country)

12 MAIDEN NAME OF MOTHER Barbara Fandrifluh

13 BIRTHPLACE OF MOTHER (city or town) Pa
(State or country)

14 Informant Mrs Laura Le Coburn
(Address) 1636 N Fulton

15 Filed JUL 6 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5" 1923

17 I HEREBY CERTIFY, That I attended deceased from Apl 23 1923 to July 5" 1923,

that I last saw h/she alive on July 5" 1923

and that death occurred, on the date stated above, at 4.50 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

About 5 yrs. — mos. — ds.
(duration)

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopic.

(Signed) O. N. Duvall, M. D.

(Address) 1817 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet	June 9 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77313

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77313

CERTIFICATE OF DEATH. 1888-001

1 PLACE OF DEATH Mercy Hospital — REGISTERED NO. C

CITY OF BALTIMORE (No. ..... ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Wm. P. Lawrence

(Residence in Baltimore: No. 2 years 2004 N. ~~Charles~~ Liberty St., yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ (*Write* the word.) single

6-DATE OF BIRTH, Feb 17 — 1895, 1 (Month) (Day) (Year)

7-AGE, 28 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... R Room
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), md

PARENTS.

10-NAME OF FATHER, Antonia Lawrence

11-BIRTHPLACE OF FATHER (State or Country), Poland.

12-MAIDEN NAME OF MOTHER Mary Samonski

13-BIRTHPLACE OF MOTHER (State or Country), Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. L. Forrestor

(Address) 1627 St Paul St

15- Filed JUL 6 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 6, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed Chest Injury Left Hand 2
Comp. Fract. Left Radius Left Foot
& Left Arm almost amputated. 1 1/2 hrs
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Whitty M. D. (Coroner.)

July 6, 1923 (Address) 1639 Bway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Md — DATE OF BURIAL, July 7, 1923

20-UNDERTAKER Wm Leask for E. Lynch Sr — ADDRESS

NOTE.—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D77314

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 D77314

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 Loneys lane ST., 76 WARD)

2-FULL NAME John Franklin Keeley.

(a) RESIDENCE No. 319 Loneys lane ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (or) WIFE of: ——

6 DATE OF BIRTH (month, day, and year) Apr 2-1922

7 AGE — Years: / Months: 3 Days: 4 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER James L Keeley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER Mary Rockhan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant (Address): James L Keeley 319 Loneys lane

15 Filed JUL 6 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1923

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1923, to July 6, 1923, that I last saw him alive on July 6, 19..., and that death occurred, on the date stated above, at 12-10 P m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

July 6, 1923 (Address) 2004 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetary — DATE OF BURIAL: July 7, 1923

20 UNDERTAKER: John Ellicott — ADDRESS: 2025 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77315

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 D77315

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1047 Hollen St ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A. Burrows

(a) RESIDENCE NO. 1047 Hollen ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 9 1842

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
81	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Connecticutt

PARENTS

10 NAME OF FATHER Joseph B Burrows

11 BIRTHPLACE OF FATHER (city or town) (State or country) Connecticutt

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Elmer Burrows

(Address) 1047 Hollen ave

15 JUL 6 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/6 1923

17 I HEREBY CERTIFY, That I attended deceased from 7-1 1923 to 7-6 1923.

that I last saw him alive on 7-5 1923,

and that death occurred, on the date stated above, at 8.30 a m.

The CAUSE OF DEATH* was as follows:

Senility

Arteriosclerosis

Uremia (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. 0 mos. 1½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Weiss, M. D.

, 19 (Address) 914 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Congressional Cemetery Washington D. C. DATE OF BURIAL July 7 1923

20 UNDERTAKER Jenny Lutz ADDRESS 1203 N Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77316 ✓ D77316

D77316

CERTIFICATE OF DEATH.

38

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 827 W Franklin St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Harmon

(a) Residence No. 827 W. Franklin St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed or Divorced (Write the word.)
FEMAL,	COLORD,	WIDOW

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1890

7-AGE.	If LESS than 1 day,
33, yrs. mos. ds.	hrs. or. min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work COOK,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), BALTIMORE, CITY,

PARENTS.

10-NAME OF FATHER, DONT KNOW,

11-BIRTHPLACE OF FATHER (city or town) (State or Country), MD,

12-MAIDEN NAME OF MOTHER, DONT KNOW,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), MD,

14- (Informant) MRS, MARTHA JOHNS,

(Address) 827 W. FRANKLIN ST,

15- JULY 6 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 6-1923

17- I HEREBY CERTIFY, That I attended deceased from July 4, 1923 to July 5 1923

that I last saw her alive on July 4 1923.

and that death occurred, on the date stated above, at 12-15 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. One ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. R. Lazenby M. D

, 19 (Address) 753 Scott St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
MT. AUBURN, CEM,	7-7-, 1923
20-UNDERTAKER. Daniel Easton	ADDRESS 916 Pa ave

Exact statement of OCCUPATION is very important. See instructions on back of certificates. Certificates may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D77317

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77317

57

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1010 Union Ave. ST., 13 WARD)

2-FULL NAME Minnie Florence Fisher

(a) RESIDENCE NO. 1010 Union Ave. ST., WARD 13

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John M. Fisher

6 DATE OF BIRTH (month, day, and year): Sept [illegible] 1867

7 AGE: Years 55 Months 10 Days ... If LESS than 1 day, hrs. or min. ...

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Co.

PARENTS

10 NAME OF FATHER: Thomas Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Cornelia Bull

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: John M. Fisher

(Address): 1010 Union Ave.

15 JUL 6 - 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5 1923

17

I HEREBY CERTIFY, that I attended deceased from June 1, 1917, to July 5, 1923,

that I last saw h[illegible] alive on July 4, 1923,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 6 yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical & Chemical tests

(Signed) R. B. Norwood M. D.

7.5. 1923 (Address) 9147 Chadwick Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westburg Cemetery — DATE OF BURIAL: July 7, 1923

20 UNDERTAKER: E. LeRoy Stiffler — ADDRESS: 125 E Baltimore

IMPORTANT.—Physicians should state DISEASE CAUSING DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D77318 HEALTH DEPARTMENT—CITY OF BALTIMORE D77318

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eberhardt Edelmann

(a) Residence No. 73 X W. Balto St., Ward B-22
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 25-1871

7-AGE, 52 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) night watchman

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Frederick Edelmann

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Sophie ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

11- (Informant) Hospital Records

(Address)

13- JUL 6 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 6-1923

17- I HEREBY CERTIFY, That I attended deceased from June 29, 1923 to July 6, 1923 that I last saw h[illegible] alive on July 6, 1923 and that death occurred, on the date stated above, at 12.02 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

Embolism.
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia — Pulmonary Edema
(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 7/2/23.

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) H. W. Holley, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, New Cathedral — DATE OF BURIAL, 7-9-1923

20-UNDERTAKER, H. C. Brauns & Son — ADDRESS 517 N. Schroeder St

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77319

CERTIFICATE OF DEATH.

45 D77319

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 1416 N. Broadway ST., 8 (WARD)

2-FULL NAME Ida. B. Smith

(a) RESIDENCE NO. 1416 N. Broadway ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James H. Smith

6 DATE OF BIRTH (month, day, and year): Sept 22-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. City

PARENTS

10 NAME OF FATHER: Charles Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary A. Tracy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Mrs. Howard Keller 1112 Eastern Ave

15 Filed JUL 6 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1922, to July 5, 1923, that I last saw h alive on July 4, 1923, and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Carcinoma Abdomen

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of Mch 9/23

Was there an autopsy? yes

What test confirmed diagnosis? Operation

(Signed) Alan B Lemmon M. D.

July 5, 1923 (Address) 911 N Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 7 '23
UNDERTAKER	ADDRESS
A. S. Marshall	3539 Fall Rd

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77320 HEALTH DEPARTMENT—CITY OF BALTIMORE **D77320**

106-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 618 West Lee St (Street) (ST.) (WARD) 23

2-FULL NAME Eva Jobes

(a) RESIDENCE NO. 1003 Leadenhall ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Oct 6. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	0	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): 1003 Leadenhall St

PARENTS

10 NAME OF FATHER: Henry Jobes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bath Md

12 MAIDEN NAME OF MOTHER: Eleanor Clark

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Eleanor Jobes

(Address): 1003 Leadenhall St

15 JUL 7 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5. 1923

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1923, to July 5, 1923.

that I last saw her alive on July 5, 1923

and that death occurred, on the date stated above, at 9. 45 p m

The CAUSE OF DEATH* was as follows:

Spasms Pneumonia

(duration) yrs. 8 mos 29 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No Knowledge

Did an operation precede death? no. Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) William H. Dodd M. D.

, 19 (Address) 1111 Johnson Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Ct. DATE OF BURIAL: July 7 1923

20 UNDERTAKER: J. H. Broome & Son ADDRESS: 458 W Monty

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77321

CERTIFICATE OF DEATH.

49 D77321

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: No. E. Monument ST.: 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Collins

(a) RESIDENCE. NO. 418 S. Highland ST.. 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 5 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Lina Collins.

6 DATE OF BIRTH (month, day, and year) Jan 31st 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

045

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Rebecca Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Franklin Collins.
(Address) 418 S. Highland Ave.

15 JUL 7 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1923

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1923, to July 5, 1923, that I last saw h~~im~~live on July 5, 1923, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Pyelo-nephritis

(duration) several mos.

CONTRIBUTORY (Secondary) Carcinoma of Prostate

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Isidore L. Jury M. D.

. 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	July 9th 1923

20 UNDERTAKER Lilly & Zeiler ADDRESS 400 S. Wolfe

TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D77322

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-001 D77322

1-PLACE OF DEATH

REGISTERED NO. 22

CITY OF BALTIMORE: (No. South Baltimore General Hosp ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Gallamore.(C).

(a) RESIDENCE NO. 139 W.Hill St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Gallamore.(C).

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer) Monumental
(c) Name of employer Stevedoring Co.

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Mary Gallamore.(C)(wife). (Address) 139 W.Hill St.

15 Filed JUL 7 192- 1923 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally run over by B & O R R. car. Crushed about the limbs. Shock. (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt (Coroner) M. D.

July 6, 192 3. (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death? Accident

Pier 2. Locust Point July 5, 1923.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL July 7 1923

20 UNDERTAKER John H. Toadvine ADDRESS 142 Wilkens Ave

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77323

CERTIFICATE OF DEATH.

54-001 D77323

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1403 May ST., 5 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Spencer

(a) RESIDENCE NO. 1403 May ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 52 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rachel Spencer

6 DATE OF BIRTH (month, day, and year): Aug 25-1870

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
52	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): General

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Frances Robins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ga.

14 Informant: Josephine Swayne

(Address): 524 N. Bethel St

15 Filed JUL 7 - 1923 E.G. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 4 1923

17 I HEREBY CERTIFY, That I attended deceased (from July 4, 1923. to July 4, 1923.

that I last saw him alive on July 4, 1923.,

and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) High Blood Pressure

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Balto. Md.

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. C. Robinson M. D.

7/6, 1923 (Address) 1520 Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Alsbury Cemetery DATE OF BURIAL July 8 1923

20 UNDERTAKER: Chas. H. Johnson ADDRESS 467 N. Gay St.

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D77324 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6761-001

D77324

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 130 N. Castle St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Holly

(Residence in Baltimore: No. 130 N. Castle St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	single

6-DATE OF BIRTH. April 10/23 1.....
(Month) (Day) (Year)

7-AGE. ..... yrs. 2 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS

10-NAME OF FATHER, Frank Holly

11-BIRTHPLACE OF FATHER, (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Minnie Perry

13-BIRTHPLACE OF MOTHER, (State or Country), Caroline Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Holly

(Address) 130 N. Castle St.

15- Filed JUL 7 - 1923 GLG Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 5/23, 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Malnutrition- Prematurity about 8 months gestation

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) J. S. H. Coll. M. D.
(Coroner.)

7/6/23 192... (Address) 503 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	July 7, 1923
20-UNDERTAKER. Burkhardt Burkhardt	ADDRESS 1739 Eager

If very important. See instructions on back of certificate. Should be properly classified. Exact statement of OCCUPATION may be

Spec.—1-10-21—M&T—1500 Bks.

D77325 HEALTH DEPARTMENT—CITY OF BALTIMORE

D77325

CERTIFICATE OF DEATH.

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2746 Maryland Ave ST. 12 WARD)

2-FULL NAME Texanna Columbia Thornton

(a) RESIDENCE NO. 2746 Maryland Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

5a If ~~married~~, widowed, ~~or divorced~~ ~~HUSBAND OF~~ (or) WIFE of Samuel Thornton

6 DATE OF BIRTH (month, day, and year) Apl.24.1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va.

PARENTS

10 NAME OF FATHER Frances Edmonds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. Samuel T. Beale
(Address) 2746 Maryland Ave

15 Filed JUL 7 - 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4. 1923 19

17 I HEREBY CERTIFY, That I attended deceased from July 3, 19 23, to July 4, 19 23, that I last saw h[illegible] alive on July 3, 19 23, and that death occurred, on the date stated above, at 6:00 P m.

The CAUSE OF DEATH* was as follows:

Chronic hypertrophic

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible] M. D.

7/6, 19 23 (Address) 2117 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 7-7-23 19

20 UNDERTAKER H.E. Hughes — ADDRESS 424 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77326

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D77326

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 N. Bruce ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lula Ellen Barrett

(a) RESIDENCE. No. 315 N. Bruce ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of James Barrett.

6 DATE OF BIRTH (month, day, and year) Nov 28, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife — 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self- Housekeeper

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Everett Seger.

11 BIRTHPLACE OF FATHER (city or town) Essex Co (State or country) Va.

12 MAIDEN NAME OF MOTHER Lettie Corbett

13 BIRTHPLACE OF MOTHER (city or town) Essex Co (State or country) Va.

14 Informant James Barrett.
(Address) 315 N Bruce St.

15 Filed JUL 7 - 1923 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1923

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1923, to July 3, 1923, that I last saw her alive on July 2, 1923, and that death occurred, on the date stated above, at 10,30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Environment

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 315 N. Bruce

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Sputum

(Signed) Julian A. Wright, M. D.

(Address) 1203 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	July 19..

20 UNDERTAKER Peter F. Williams ADDRESS 1515 McCulloh St

IT may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77327

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City or BALTIMORE: (No. Hospital 28 Ward)

2-FULL NAME Duncan Dr Bell

(Residence in Baltimore: No. 4206 Comm Ave St.; yrs.,.....mos.....ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1788-003

D77327

Registered No. C.....

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

6-DATE OF BIRTH: ..... (Month) ..... (Day) 85 (Year)

7-AGE: 67 ..... yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Inspector Lamps
(b) General nature of industry, business, or establishment in which employed (or employer): Electric Bulb Co

9-BIRTHPLACE (State or Country): Balto

PARENTS.

10-NAME OF FATHER: John H De Bell

11-BIRTHPLACE OF FATHER, (State or Country): France

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ferd H Bell

(Address) 4206 Comm Ave

15-

Filed JUL 7 - 1923

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 4 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows: Multiple Fractures Auto Accident.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jack Broder M. D.

July 7 23 (Coroner) (Address) 1436 Bway

(State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: Greenmount DATE OF BURIAL: July 11th 19 23

20-UNDERTAKER: H R Hoppert ADDRESS 22 E Fred Ave

If very important. See instructions on back of certificate. Name may be properly classified. Exact statement of OCCUPATION

Spec—12-23-21—E.B.R.S.—400 Bks.

D77328 HEALTH DEPARTMENT—CITY OF BALTIMORE 89 D77328

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No 3120 Wilkins Avenue St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas B. Anderson

(a) Residence No. 3120 Wilkins Ave, St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Anderson

6-DATE OF BIRTH (month, day and year) Apr. 23, 1862

7-AGE.	If LESS than 1 day.
61 yrs. 2 mos. 13 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) O.K.

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto.
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Henry Anderson

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Rose Carner

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country), Ireland

11- (Informant) Lillian Whitaker
(Address) 3120 Wilkins Ave.

15- Filed JULY-1923 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 5, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 5, 1923 to July 5, 1923 that I last saw him alive on July 5, 1923 and that death occurred, on the date stated above, at.....m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac dilitation

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy?.....

What test confirmed diagnosis? Clinical

(Signed) Edw. T. Coolahan, M. D.

7/6, 1923 (Address) 24 N. Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Western Cenetary	July 9, 1923
20-UNDERTAKER.	ADDRESS
F. B. Wippert	2236 Fred. Ave.

Instructions on back of certificates. Exact statement of OCCUPATION is very important. See that property entitled.

Spec.—1-10-21—M&T—1500 Bks.

D77329

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77329

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2244 Booth St. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline F. Beck

(a) RESIDENCE No. 2244 Booth ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 2 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Beck

6 DATE OF BIRTH (month, day, and year) April 9-185?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Conradi

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. J. Beck
(Address) 2177 Carlton St

15 Filed JUL 7 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5th 1923

17

I HEREBY CERTIFY, That I attended deceased from June 6th, 1923, to July 5th, 1923,

that I last saw her alive on July 5th, 1923,

and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Hauff, M. D.

19 (Address) 1843 W. Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 7 19 23
20 UNDERTAKER	ADDRESS
F. C. Wagner & Son	845 Fulton Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D77330 HEALTH DEPARTMENT—CITY OF BALTIMORE D77330

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Miller

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE William ? Miller

6-DATE OF BIRTH (month, day and year) 1842

7-AGE. 80 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Leonard Householder

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Hagerstown, Md.

12-MAIDEN NAME OF MOTHER, Margaret Macklehenery

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penngylvania

14-(Informant) Municipal Hospital Records

(Address)

JUL 7 - 1923

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 5, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 16 19 23 to July 5 19 23

that I last saw h[illegible]er alive on July 5 19 23

and that death occurred, on the date stated above, at 4:00 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma ? Cervix

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumia

Terminal (Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Wm. J. Sellin M. D.

7-6-, 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn DATE OF BURIAL. July 7 1923

20-UNDERTAKER, Chenowith & Son ADDRESS Chestnut Ave

Instructions on back of certificates. Exact statement of OCCUPATION is very important. See

D77331

HEALTH DEPARTMENT--CITY OF BALTIMORE

D77331

CERTIFICATE OF DEATH

94-001

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 21 E.Montgomery ST. 2-2 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Annie V.Cook

(Residence in Baltimore: No. 21 E.Montgomery St.: 50 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: October (Month) 1 (Day), 1848 (Year)

7 AGE: 74 yrs. 9 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: House-work
(b) General nature of industry, business, or establishment in which employed (or employer): At home

9 BIRTHPLACE (State or country): Dorchester Co. Md

PARENTS

10 NAME OF FATHER: Samuel Craig

11 BIRTHPLACE OF FATHER (State or country): Dorchester Co. Md.

12 MAIDEN NAME OF MOTHER: Mary A.Bell

13 BIRTHPLACE OF MOTHER (State or country): Dorchester Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Levin P.Cook (Husband)
(Address) 21 E.Montgomery St.

15 DATE RECEIVED JUL 7 - 1923 191 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 3 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2, 191, to July 3 1923, that I saw h[illegible] alive on July 3, 1923, and that death occurred, on the date stated above, at 11 P. m.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mns. 2 ds

Contributory (SECONDARY)

(Duration) yrs. mns. 2 ds.

(Signed) H.D.Smith M. D.

July 5, 1923 (Address) 109 N. Eutaw St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death: yrs. mos. ds. In the State: yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park Cemetery — DATE OF BURIAL: July 7, 1923

20 UNDERTAKER: John F Denny — ADDRESS: 715 Light St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D77332 HEALTH DEPARTMENT—CITY OF BALTIMORE D77332

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 N. Ellwood Ave WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Forster

(a) RESIDENCE NO. 604 N. Ellwood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Otto C. Forster

6 DATE OF BIRTH (month, day, and year) June 26/57

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	—	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 03

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Schrank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Otto C. Forster (Address) 604 N. Ellwood Ave

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1923

17

I HEREBY CERTIFY, That I attended deceased from June 29 1923 to July 5 1923 that I last saw h alive on July 5 1923 and that death occurred, on the date stated above, at 6.00 a. m.

The CAUSE OF DEATH* was as follows:

Ulcerated Regurgitation

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Finding

(Signed) [illegible] M. D.

(Address) 1000 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 7/8 1923

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Aliceanna

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- it may be properly classified. PHYSICIANS should state in plain terms, so that

JLT-1923

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77333

CERTIFICATE OF DEATH.

90 D77333

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 2-W-26th ST. 12 WARD)

2-FULL NAME Mrs. Louise Perkins

(a) RESIDENCE NO. 2-W-26th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis Perkins

6 DATE OF BIRTH (month, day, and year) Aug. 22 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md

PARENTS

10 NAME OF FATHER George Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Buttery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Lettie R. Buchman

(Address) 2. W. 26th St.

15 Filed JUL 7 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1923

17

I HEREBY CERTIFY, That I attended deceased from May 15, 1923, that I last saw him alive on July 4, 1923, and that death occurred, on the date stated above, at 2.00 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease
Mitral Insufficiency

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Irvin Eberhart, M. D.

(Address) 401 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL July 7 1923

20 UNDERTAKER George L. Schwatt — ADDRESS 2101 Eutaw Ave.

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- may be properly classified. PHYSICIANS should state in plain terms, so that it

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77334

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 159-002 D77334

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1825 N Dallas St.; WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roland Collison

(a) RESIDENCE. No. 1825 N. Dallas ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/7/23

7 AGE — Years — Months — Days — If LESS than 1 day, — hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Roland Collison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt md.

12 MAIDEN NAME OF MOTHER Anna Albers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt. Md.

14 Informant Roland Collison
(Address) 1825 N. Dallas St.

15 Filed JUL 7 - 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1923

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1923, to July 7, 1923, that I last saw him alive on July 7, 1923 and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Con. genital Cardiac Insufficiency

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A Owens, M. D.

19 (Address) 1603 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent's Cem. DATE OF BURIAL: 7/11/23

20 UNDERTAKER: Geo. J. Ruth. ADDRESS: 1735 Hoffman Ave.

TION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Bks.

D77335 HEALTH DEPARTMENT—CITY OF BALTIMORE D77335

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 124

City of BALTIMORE: (No. Municipal Hospital St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Grimsehl

(a) Residence No. 2207 Baudaf St

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1880

7-AGE. 42 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Printer ~~Printer~~

(b) General nature of industry, business, or establishment in which employed (or employer) 063

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, George Grimsehl

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Municipal Hospital Records

(Address)

15- Filed JUL 7 1923 19 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 1, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 26 19 23 to July 1 19 23

that I last saw h.. im.. alive on July 1 19 23

and that death occurred, on the date stated above, at 8:35 P. M.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Terminal) (Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) N. Goldsmith M. D.

7-3- 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL. July 7th 19 23

20-UNDERTAKER. A. Jones

ADDRESS. 111 S Gilmor

Instructions on back of certificates.

Exact statement of OCCUPATION is very important. See

Spec.—1-10-21—M&T—1500 Bks.

D77336

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 57 ✓ D77336

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4308 Walnut ST., 28 WARD)

2-FULL NAME Sarah Ellen Williams

(a) RESIDENCE No. 4308 Walnut ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 1X ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David S Williams

6 DATE OF BIRTH (month, day, and year) May 28-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	76	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Peter Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Homer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs A Sloan Blair
(Address) 4308 Walnut

15 Filed JUL 7 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1923

17

I HEREBY CERTIFY, That I attended deceased from June 1923 to July 6 1923.

that I last saw h.. alive on July 6 1923.

and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Gangrene of foot.

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Penn

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Marshall B Lorat M. D.

July 7 19 23 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL York Pa.

DATE OF BURIAL July 19 23

20 UNDERTAKER W M Routson

ADDRESS 2238 N

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77337 HEALTH DEPARTMENT—CITY OF BALTIMORE

94-00 D77337

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1910 Argyle ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Gibson

(a) RESIDENCE. NO. 1910 Argyle ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 3, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Robt Green

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md

12 MAIDEN NAME OF MOTHER Emma Marshall

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Robt Green
(Address) 1910 Argyle Ave

15 Filed . 19 Registrar

JUL 7 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1923

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1923, to July 5, 1923.

that I last saw him alive on July 5, 1923.

and that death occurred, on the date stated above, at 10:45 a.m.

The CAUSE OF DEATH* was as follows

Acute Bronchitis.

(Duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Teething and Convulsions (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical Evidence

(Signed) P. Carlos Schmidt M. D.

1923 (Address) 1534 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	7/7/23 19
20 UNDERTAKER George J. Kuhl	ADDRESS 1735 Eutaw

IMPORTANT: PHYSICIANS should fill out all parts of this certificate, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D77338

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77338

CERTIFICATE OF DEATH.

6 74-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1a.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General ST., Hospital WARD)

2-FULL NAME Emmett R. Charles.

(a) RESIDENCE NO. 108 N. Bradford St, ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? 29 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed or divorced
HUSBAND of (or) WIFE of Louise Charles.

6 DATE OF BIRTH (month, day, and year) August 17th. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54	10	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman 062
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Chesapeake S/S Co.

9 BIRTHPLACE (city or town) (State or country) Richmond, Va.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Louise Charles. (wife)
(Address) 108 N. Bradford St.

15 Filed JUL 7 - 1923 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4th. 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Ghoblexr.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner)

July 5th. 1923 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery DATE OF BURIAL July 7 1923

20 UNDERTAKER Chas C. Miller ADDRESS 2334 Jefferson

Cut on dotted line and paste on back of certificate. See instructions on back of statement of OCCUPATION. Very important.

Spec.—1-10-21—M&T—1500 Bks.

16467 D77339

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D77339
REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 5
CITY OF BALTIMORE: (No. ..... ST., ... WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Randolph Blackwell

(a) RESIDENCE NO. 1047 N. Front ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 6 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE of~~ Sarah

6 DATE OF BIRTH (month, day, and year) — 1873

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
50	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS
10 NAME OF FATHER Charles Blackwell
11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C
12 MAIDEN NAME OF MOTHER Frances Robertson
13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 JUL 7 - 1923 E. H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1923

17 I HEREBY CERTIFY, That I attended deceased from June 25 1923, to July 6 1923, that I last saw him alive on July 6 1923, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency
(duration) yrs. 6 mos ds.
CONTRIBUTORY (Secondary) Pulmonary oedema
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of None
Was there an autopsy? Yes
What test confirmed diagnosis? autopsy

(Signed) Chas. R. Bagley, M. D.
19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Zion Cemetery German July 9 1923
UNDERTAKER Mrs. H. A. Elliott. ADDRESS 1727 Eastlondon

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77340 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77340

CERTIFICATE OF DEATH.

58-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2232 Linden Ave. WARD)

2-FULL NAME Minnie H. Nusbaum

(a) RESIDENCE No. 2232 Linden Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mat Nusbaum

6 DATE OF BIRTH (month, day, and year): Oct. 30, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Moses H. Hirshberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Sophie Goldsmith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mr. Isaac Hirshberg

(Address) 2232 Linden Ave

15 Filed JUL 7 - 1923 Harry Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/7/1923

17 I HEREBY CERTIFY, That I attended deceased from June, 1923, to July, 1923.

That I last saw her alive on July 7, 1923,

and that death occurred, on the date stated above, at 4309 m.

The CAUSE OF DEATH* was as follows:

Pernicious anemia

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): Exhaustion + toxemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J. Frederick Lentz, M. D.

7-8, 1923 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem.

DATE OF BURIAL: 7/9/1923

20 UNDERTAKER: David Sondheim

ADDRESS 1836 W. Mt. Royal Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- at it may be properly classified. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

D77341 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-001 ✓

CERTIFICATE OF DEATH. D77341

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 603 China ST. 21 WARD) REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Handy

(a) RESIDENCE NO. 603 China ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1919

7 AGE 45 Years | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER John Blyth

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER annie King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Clara Turner (Address) 603 China St

15 FILED JUL 7 - 1923 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 - 1923

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1923, to July 6, 1923, that I last saw her alive on July 5, 1923, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) ... yrs. ... mos 1 dy

CONTRIBUTORY (Secondary) Paralysis & Bright Disease (duration) ... yrs. 6 mos 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D Gillenward M. D.

7-6. 1923 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loue Point md | DATE OF BURIAL July 8th 1923

20 UNDERTAKER Joseph A Farrell | ADDRESS 2319 Dunbar

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77342

CERTIFICATE OF DEATH.

16-002 D77342

1-PLACE OF DEATH Nursery + Child's Hospital

CITY OF BALTIMORE: (No. Franklin + Schroeder ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Baker

(a) RESIDENCE NO. 1312 N Monford ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dec 25, 1922

6 DATE OF BIRTH (month, day, and year) July 6, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Raymond Baker

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Pauline Schwering

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Raymond Schwering (Address) 13 N. Monford ave

15 Filed JUL 7 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1923

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1923, to July 6, 1923, that I last saw him alive on July 6, 1923, and that death occurred, on the date stated above, at 11.45 P.m.

The CAUSE OF DEATH* was as follows:

Dysentery (bacillary)

(duration) yrs. mos. 35 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Lawson Wilkins, M. D.

July 6, 1923 (Address) 1014 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem

DATE OF BURIAL 19

20 UNDERTAKER Wm Cook

ADDRESS 502 E North Ave

TION is very important. See instructions on back of certificates. may be properly classified. Exact statement of OCCUPA- PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

D77343

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77343

CERTIFICATE OF DEATH.

31 D 77343

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 S. Schroeder ST., 18 WARD)

2-FULL NAME Margaret E. King

(a) RESIDENCE NO. 110 S. Schroeder ST., ... WARD .....
(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 38 yrs. 4 mos. ds. How long in U. S., if of foreign birth? 38 yrs. 4 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Patrick King

6 DATE OF BIRTH (month, day, and year): Feby 1885

7 AGE — Years: 38 — Months: 4 — Days: — If LESS than 1 day, hrs. or ... min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: James McHugh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Margaret Coady

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Patrick King
(Address) 110 S Schroeder St.

15 Filed JUL 8 - 1923 ROBERT R. KRAMER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1922, to July 6 1923, that I last saw h alive on July 5 1923, and that death occurred, on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum exam.

(Signed) Conrad R. Kuhn M. D.

, 19 (Address) 999 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 7/9 1923

20 UNDERTAKER: John A. Moran — ADDRESS: 3500 E. Balto.

TION is very important. See instructions on back of certificates. Exact statement of OCCUPATIONS should state be properly classified.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77344

CERTIFICATE OF DEATH.

7H-001 D77344

1-PLACE OF DEATH Mrs Carters Sanatarium REGISTERED NO. C

CITY OF BALTIMORE: (No. Belvedere & Bellona Av ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Caroline Wroth

(Residence in Baltimore: No. Belvedere & Bellona Av St.; ..... yrs., mos. 4 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, June ? ?, 1861 (Month) (Day) (Year)

7-AGE, 62 ? ? yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country), Chestertown Md

PARENTS.

10-NAME OF FATHER, ? ?? Cabeb

11-BIRTHPLACE OF FATHER (State or Country), Chestertown - Md

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. L. Sodd -

(Address) Chestertown - Md

15- JUL 8 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 7, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1923, to July 7 1923, that I saw her alive on July 7 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ....yrs. ....mos. 1 ....da.

CONTRIBUTORY (Secondary)

..... (Duration) ....yrs. ....mos. ....da.

(Signed) E. M. Duncan M. D.

July 7, 1923 (Address) 5106 York Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 4 ds. In the State 62 yrs. ? mos. ? ds.

Where was disease contracted, if not at place of death? at place of Death

Former or usual residence Chestertown Md

19-PLACE OF BURIAL OR REMOVAL, Chestertown Md DATE OF BURIAL, July 8, 1923

20-UNDERTAKER, STEVENS & MOWEN COMPANY (WILLIAM F. WOODEN, Manager) ADDRESS 108 W. NORTH AVE.

Fill in all blanks. Use ditto marks. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1C D77345

CERTIFICATE OF DEATH.

101-001 D77345

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. #109-Beechdale-Road. ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CHARLES LEWIS WAGANDT

(a) RESIDENCE NO. #109-Beechdale-Road. ST., 27 WARD ([redacted])
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. [redacted] mos. [redacted] ds. How long in U. S., if of foreign birth? 60 yrs. [redacted] mos. [redacted] ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Eliza Wagandt.

6 DATE OF BIRTH (month, day, and year) July--11-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory Manager of the

(b) General nature of industry, business, or establishment in which employed (or employer) K & H Branch of the

(c) Name of employer Nat. Enam. and Stampg. Co.

9 BIRTHPLACE (city or town) (State or country) ~~Baltimore~~ ~~Maryland~~ Germany

PARENTS

10 NAME OF FATHER Henry Wagandt

11 BIRTHPLACE OF FATHER (city or town) not known (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Hillman

13 BIRTHPLACE OF MOTHER (city or town) not known (State or country) Maryland

14 Informant Mr. Chas. E. Wagandt, (son)
(Address) 109-Beechdale Road, City.

15 JUL 8 - 1923 ROBERT M. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1923

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1923, to July 7, 1923, that I last saw him alive on July 7, 1923, and that death occurred, on the date stated above, at 9.40 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia. Spreading to whole R. lung. Patch in L. lung

(duration) yrs. mos. 35 ds.

CONTRIBUTORY (Secondary) Bacteraemia

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? Baltimore.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) Frank R. Smith, M. D.

July 7 1923 (Address) 927 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: WOODLAWN CEMETERY — DATE OF BURIAL: JULY-9-23

20 UNDERTAKER: STEWART & MOWEN COMPANY (Signed) F. MOWEN, Manager — ADDRESS: 108 W. NORTH AVE.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77346

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-00/D77346

1-PLACE OF DEATH

CITY OF BALTIMORE:-(No. Municipal Hospital. St., 15 Ward)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Queen

(a) RESIDENCE No. 1305 Winchester St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)... (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed ....., 19.... ROBERT R. KRAUTER, Registrar

JUL 8 - 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 7, 19 23, to July 4, 19 23, that I last saw him alive on July 4, 19 23, and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Terminal) (duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Goldsmith, M. D.

7-5-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lutherans Rd.	July 8 1923
20 UNDERTAKER	ADDRESS
Lewis Spence	313 Lee St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- ...it may be properly classified. PHYSICIANS should state ...all terms, so that it ma...

Cor.—1-12-23—M&T—100 Bks.

D77347

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1835 D77347

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp. ST., V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William T. Winns

(a) RESIDENCE NO. 1924 Alicanna St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 5, 1877

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
46	5	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) General
(c) Name of employer Atlantic Can Co.

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Winns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Alice Hauss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Annie Winns
(Address) 1924 Alicanna St

15 Filed JUL 8 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Heart Failure
Acute, Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. J. Kennedy, M. D.
(Coroner.)
July 9, 1923 (Address) 10 E. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State 46 yrs., 5 mos., 28 ds.

Where was disease contracted, if not at place of death?

Former or usual residence 1924 Alicanna

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County — DATE OF BURIAL July 9 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E Nor

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77348

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

113 . D77348

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 S. Bond ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donrad Shalan

(a) RESIDENCE. No. 103 S Bond ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 9 /22

7 AGE — Years: — Months: 11 Days: 15 If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Joseph Shalan Baltimore

PARENTS

10 NAME OF FATHER: Joseph Shalan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Edele Hzlenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Joseph Shalan 103 S Bond St

15 Filed JUL 8 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1923

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1923, to July 7, 1923, that I last saw him alive on July 7, 1923, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Ulcer. Colitis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cholera - Infantum

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M.D.

July 7, 1923 (Address) 1451 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: July 9 1923

20 UNDERTAKER: Ernest Encelson — ADDRESS: 1906 Eutaw

IMPORTANT—Causes of death must be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Itks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77349

D77349

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Barge #1 Arundel Corporation, ST., Masonville. (WARD) 25 X 202

2-FULL NAME Jack Brown.

(a) RESIDENCE NO. Barge #1. Masonville. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred -- yrs. 1 mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... Laborer. #10
(b) General nature of industry, business, or establishment in which employed (or employer) Arundel Corporati
(c) Name of employer on.

9 BIRTHPLACE (city or town) (State or country) Sperryville Va.

PARENTS

10 NAME OF FATHER William Brown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Bettie Jenkins.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Ashly Jenkins.(cousin). (Address) Curtis Bay.

15 JUL 8 - 1923 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of the neck.
Occidentally struck on the back of hi
neck by a descending iron bar on barg

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M Reinhardt (Coroner), M. D.
July 3, 1923. (Address) 1017 E. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sperryville Va. via Culpepper B & O

DATE OF BURIAL July 8 1923

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

IMPORTANT: PHYSICIANS should state so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.P.R.S.—400 Bks.

D77350

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113

D77350

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Joseph Loetz

(a) Residence No. 1144 Cleveland St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 7 1921

7-AGE. 1 yrs. 11 mos. 27 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Balto. (State or Country),

PARENTS.

10-NAME OF FATHER. Herman Loetz

11-BIRTHPLACE OF FATHER (city or town) Md. (State or Country),

12-MAIDEN NAME OF MOTHER. Marie Clark

13-BIRTHPLACE OF MOTHER (city or town) Balto Md (State or Country),

14- (Informant) Hospital Records

(Address)

15- Filed JUL 8 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 7/23

17- I HEREBY CERTIFY, That I attended deceased from July 3 19 23 to July 7 19 23

that I last saw him alive on 19

and that death occurred, on the date stated above, at 5.30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

2 week.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (Bronchial)

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? 1144 Cleveland St.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) K. W. Dilley M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cem DATE OF BURIAL. 7/8/23

20-UNDERTAKER. Engel & Foley ADDRESS. Fallsway & Fayette

Instructions on back of certificates. Exact statement of OCCUPATION is very important. See

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77351

CERTIFICATE OF DEATH.

5 15 ✓ 5 D77351

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma Courtice

(a) Residence No. 3901 Norfolk Ave Forest Park. St., Ward 30 1

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white.	widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1858

7-AGE.	If LESS than 1 day.
65 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Penna.

PARENTS.

10-NAME OF FATHER, John Norbeck.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Penn.

12-MAIDEN NAME OF MOTHER, Mary Ann Hauer

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Penn.

14- (Informant) Hospital Record

(Address)

15- Filed JUL 8 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 6 1923

17- I HEREBY CERTIFY, That I attended deceased from July 6, 1923, to July 6, 1923, that I last saw h[illegible] alive on July 6, 1923 and that death occurred, on the date stated above, at. 9.25 a.m.

The CAUSE OF DEATH* was as follows: Acute

Chronic Nephritis (4 yrs)

Diabetis Mellitus (2 yrs)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma 2 hrs.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Kyle W. Holley M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
London Park Cem	7/9/23
UNDERTAKER.	ADDRESS
Joseph Finley Sons	Fayette

Instructions on back of certificates. Exact statement of OCCUPATION is very important. See

D77352

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

REGISTERED No. D77352

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1125 Druid Hill Ave ST. 11 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Maria E Wilson

(Residence in Baltimore: No. 1125 Druid Hill Ave St.: Yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 SINGLE, MARRIED WIDOWED OR DIVORCED (If write the word): Married

6 DATE OF BIRTH: Sept 29, 1870 (Month) (Day) (Year)

7 AGE: 53 yrs. 10 mo. 9 ds. If LESS than 1 day, hrs. or min?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Saml B Hutchins

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Annie M Frazier

13 BIRTHPLACE OF MOTHER (State or country): Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Basil F Hutchins

(Address) Tremont & Camden Sts Boston Mass

15 JUL 8 - 1923 ROBERT R. KRANTZ Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 6 (Day) 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1923 to July 6 1923 that I saw her alive on July 4, 1923 and that death occurred on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic pancreatitis
Cerebral Hemorrhage

(Duration) yrs. 1 mos. 4 ds

Contributory (SECONDARY) Arteriosclerosis

(Duration) 3 yrs. mos. ds.

(Signed) E L Humbert M. D.

July 7 1923 (Address) 1102 S Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Mt Auburn DATE OF BURIAL: July 8 1923

20 UNDERTAKER: Conner & Pumphrey ADDRESS: 578 Edmondson Ave

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77353

CERTIFICATE OF DEATH

44

D77353

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3721 Park Height St. WARD) 15

2-FULL NAME Benjamin Sundheim

(a) RESIDENCE NO. 3721 Park Heights Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernah Sundheim

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
72.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Judah Sundheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Bertha Stern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Isaac. Elias.

(Address) 3721 Park Heights Ave.

15 JUL 8 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7. 1923

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1923, to July 7. 1923, that I last saw him alive on July 5. 1923, and that death occurred, on the date stated above, at 9 50 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma - gall bladder

Symptoms: (duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Intestinal obstruction due to peritoneal metastasis (duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of June 10. 23

Was there an autopsy? No

What test confirmed diagnosis? Laparotomy - excision microscop. ex of a peritoneal metastasis

(Signed) Louis P. Hamburger M. D.

July 7, 1923 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Hebrew cem	7/9 1923

20 UNDERTAKER J. Ahrens Co

ADDRESS 16 W Madison

TION is very important. See instructions on back of certificates.

...PHYSICIANS should state ... Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

D77354

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 31 C-704,244 D77354

REGISTERED NO.

1-PLACE OF DEATH U. S. Veterans' Hospital No. 56

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Ft. McHenry, Md. ST., 17 WARD)

2-FULL NAME MCCARTHY, James T.

(a) RESIDENCE No. 2126 Calvert St., Baltimore, Md., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 17 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	33	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Civil Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country) unknown

14 Informant Hospital Records (Address) Ft. McHenry, Md.

15 Filed JUL 8 - 1923 ROBERT R. KRAUTER,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1923, to July 7, 1923, that I last saw him alive on July 7, 1923, and that death occurred, on the date stated above, at 11;30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis active

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Positive sputum

(Signed) H.W. Barker, Surgeon (R), M. D.

7-7-23 (Address) Medical Officer in Temp. Charge Ft. McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	7/10 1923
UNDERTAKER Chas. E. Evans & Son	ADDRESS 118 W. Mt. Roy

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77355

CERTIFICATE OF DEATH.

164 ✓ D77355

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 Brevard ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Pope

(a) RESIDENCE NO. 922 Brevard ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charleston S. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Solomon Jones

(Address) 922 Brevard St.

15 Filed JUL 9 - 1923 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 1923

17

I HEREBY CERTIFY, That I attended deceased from March, 1920 to July 6, 1923

that I last saw him alive on July 3rd, 1923,

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Senilitas of old age

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Ephum Heavy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

7/6, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	7/9/23
20 UNDERTAKER	ADDRESS
Isaiah L Brown & Son	108 N Monroe St

TION is very important. See instructions on back of certificates.

...DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77356

CERTIFICATE OF DEATH.

187-001 D77356

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Garrett Bldg ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Bailey

(Residence in Baltimore: No. 802 Edmondson Ave St.: 43 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	Colo	Married

6-DATE OF BIRTH, ..., 1880.
(Month) (Day) (Year)

7-AGE, 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Porter
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, W Bailey

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Sally Jones

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence Bailey

(Address) 802 Rutland Ave

15-

Filed JUL 9 - 1923 191 G G Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 5, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushed by Elevator
Garrett Bldg. Accidental
(Duration) yrs. mos. ds.
Prob. Fracture base 1, 2, 3 right ribs
CONTRIBUTORY (Secondary) Crushed in chest
(Duration) yrs. mos. ds.
(Signed) W. J. Kelly M. D.
(Coroner.)
July 6, 1923 (Address) 16 Eay Building

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, C B Burg Bur
DATE OF BURIAL, 7-9-23

20-UNDERTAKER, Daniel Eareckson
ADDRESS 916 Pa ave

IMPORTANT. See instructions on back of certificate. Items must be properly classified. Exact statement of OCCUPATION is very important, so that it may be [illegible]. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Bks.

D77357 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 D77357

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1330 Cleveland ST.; 21 WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Rhinehardt

(Residence in Baltimore: No. 1330 Cleveland St.; 8 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
MALE.	COLORD.	SINGLE.

6-DATE OF BIRTH, OCT. 2. 1905 (Month) (Day) (Year)

7-AGE, 17. yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... FARMER.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), MD.

PARENTS.

10-NAME OF FATHER, JOHN RHINEHARDT.

11-BIRTHPLACE OF FATHER (State or Country), M D.

12-MAIDEN NAME OF MOTHER, JULIA BREVALL.

13-BIRTHPLACE OF MOTHER (State or Country), MD.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....JULIA RHINEHARDT.....

(Address).....1330 CLEVELAND ST.....

15- JUL 9 - 1923 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 7, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 7 1923, to July 7 1923, that I saw him alive on July 7 1923, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) yrs. 1 mos. 1 week

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. A. Steadman Shirley M. D.

7 16, 1923 (Address) 638 Park Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence 6 W Hanover St.

19-PLACE OF BURIAL OR REMOVAL, MT. AUBURN. CEM. DATE OF BURIAL, 7-9-, 1923

20-UNDERTAKER Daniel Easton ADDRESS 916 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

D77358

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓

D77358

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1675 Darley Ave ST., 8 WARD)

2-FULL NAME John L. Siems

(a) RESIDENCE No. 1675 Darley Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Faith J. Siems

6 DATE OF BIRTH (month, day, and year) Sept 2. 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Civil Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Novak Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Siems

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Therese Finkenbeiner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Faith J. Siems
(Address) 1675 Darley Ave

15 FILED JUL 9 - 1923 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1923

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1923, to July 5, 1923, that I last saw him alive on July 5, 1923 and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis - Laryngeal
Pulmonary —

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Fibr Incompetis

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis A. La Brauch, M. D.

19 (Address) 2500 E. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	July 9 1923
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Eutaw St.

TION is very important. See instructions on back of certificates.

Spec.—6-3[illegible] 1000 Bks.

D77359

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D77359

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5710 Ruxleston Rd ST. 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jarrett N. Zimmerman

(a) RESIDENCE: No. 5710 Ruxleston Rd ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed or divorced HUSBAND of (or WIFE of) Sarah L. Zimmerman

6 DATE OF BIRTH (month, day, and year) Feb 20 1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Co

PARENTS

10 NAME OF FATHER: John Zimmerman

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto Co

12 MAIDEN NAME OF MOTHER: Rachel Mathews

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co

14 Informant: J. L. Zimmerman

(Address): Ruxleston Rd

15 Filed JUL 9 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-6 1923

17 I HEREBY CERTIFY, That I attended deceased from a year. to . 19 .

that I last saw him alive on 7/6 . 1923.

and that death occurred, on the date stated above, at 11.45 m.

The CAUSE OF DEATH* was as follows:

Nephritis, secondary pul-monary hemorrhage

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatology

(Signed) Henry Mudell, M. D.

7/8. 1923 Address) 3902 Groveland Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

Druid Ridge July 9 23

20 UNDERTAKER ADDRESS

A. S. Marshall 3539 Fall Rd.

IMPORTANT: Should state that if may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77360

CERTIFICATE OF DEATH.

129 D77360

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3928 Clover Hill Road ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter S. Wilkinson

(a) RESIDENCE No. 3928 Clover Hill Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 10 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Trott

6 DATE OF BIRTH (month, day, and year) Oct 27-1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	28	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Investment - Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Paris France

PARENTS

10 NAME OF FATHER Walter John Wilkinson

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice Strong

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs. Bessie Wilkinson (Address) 3928 Clover Hill Road

15 Filed JUL 9 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1923

17

I HEREBY CERTIFY, That I attended deceased from May 25 1923, to July 6 1923.

that I last saw him alive on July 6 1923,

and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis, with terminal pericarditis

(duration) 18 yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis Continuous Since Scarletina at 10 yrs (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Wm J. Watson, M. D.

, 19 (Address) 2128 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 7/9 1923

20 UNDERTAKER: Henry W. Mears & Son

ADDRESS: 805 N. Calvert

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- to that it may be properly classified. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

D77361 HEALTH DEPARTMENT—CITY OF BALTIMORE D77361

44

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1743 Carswell ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna. E. Manzke

(a) RESIDENCE No. 1743 Carswell ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if of foreign birth? 37 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: Martin A. Manzke

6 DATE OF BIRTH (month, day, and year): Nov. 18 1865

7 AGE: Years 57 Months 7 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Wm. Stenderod

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Miss Augusta Manzke

(Address) 1743 Carswell St

15 JUL 9 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1922, to July 8 1923, that I last saw her alive on July 8 1923, and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb 1 1923

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) F. J. Kinzer, M. D.

, 19 (Address) 2700 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: July 10 1923

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 1901 E Eager St

TION is very important. See Instructions on back of certificates. Exact statement of OCCUPA- may be properly classified, so that it

Spec.—1-10-21—M&T—1500 Bks.

2945

D77362

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77362

CERTIFICATE OF DEATH.

135

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1706 Mosher ST., 16 WARD)

2-FULL NAME Charles Henry Connelley

(a) RESIDENCE No. 1706 Mosher ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriett Clemmens

6 DATE OF BIRTH (month, day, and year) Oct 15 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penn

PARENTS

10 NAME OF FATHER Edmund Connelley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Elizabeth Krone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant (Address) Mrs Harriett Connelley 1706 Mosher St

15 Filed JUL 9 - 1923 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1923

17 I HEREBY CERTIFY, That I attended deceased from July 3rd, 1923, to July 7, 1923, that I last saw him alive on July 7, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma.

about 36 hrs
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Prostatitis.

(duration) 5 years yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual.

(Signed) G. Lotrote Ewalt, M. D.

7/8 1923 (Address) 2945 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn July. DATE OF BURIAL 10 1923

20 UNDERTAKER Wm Cook & Son ADDRESS

TION is very important. See instructions on back of certificates.
at it may be properly classified. Exact statement of OCCUPA-

D77363 HEALTH DEPARTMENT—CITY OF BALTIMORE 185 D77363

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Sq. Hospital 21 Registered No. C.....

City of BALTIMORE: (No. ..... St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Brown

(Residence in Baltimore: No. 229 Scott St. St.; yrs. 2 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-CONDITION. Married (Widowed or Divorced) (Write the word.)

6-DATE OF BIRTH. Oct 9 (Month) (Day) 1882 (Year)

7-AGE. 40 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work At Home
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Balto Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country) Md

12-MAIDEN NAME OF MOTHER, Mary Garrett

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leo M. Brown

(Address) 229 Scott St

15- JUL 9 - 1923 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 6 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Spine

(Duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary) Shocks.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Chalmers Rhodes M. D.
(Coroner)

7/7/23 192... (Address) 1437 N Bway

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. 5 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 229 Scott St

19-PLACE OF BURIAL OR REMOVAL, St Marys Govans DATE OF BURIAL, July 10 1923

20-UNDERTAKER, Wm Cook ADDRESS 502 E North

(Instructions on back of certificate. Exact statement of OCCUPATION)

Spec.—1-10-21—M&T—1500 Blks.

D77364

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77364

CERTIFICATE OF DEATH.

154-002

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 740 Bond ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Female Liggon Liggon

(a) RESIDENCE NO. 740 Bond ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/7/23

7 AGE Years Months Days If LESS than 1 day hrs. or min. 54

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or estsblishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Austin Liggon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C.

12 MAIDEN NAME OF MOTHER Virginia Finley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Bertha Liggon

(Address) 740 Bond St

15 Filed JUL 9 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 7th, 1923 to July 7th 1923.

that I last saw h alive on July 7th 1923.

and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Failure of Circulation from Congenital Debility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) 7 hr Minutes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) A. Fan Ellis M. D.

(Address) 724 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL July 9, 1923

20 UNDERTAKER John H Toadvine

ADDRESS 142 Mitchell

IMPORTANT. Certificate may be properly classified. Exact statement of OCCUPATIONS should state what it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77365

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-00 D77365

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1020 Riverside St., 24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary A Schrifogle

(a) RESIDENCE NO. 1020 Riverside St., 24 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm N. Schrifogle

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Worcester Co. Md.

PARENTS

10 NAME OF FATHER Chas. Massey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Caulk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mrs Chas L Schrifogle 68 N Fremont

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1923

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to July 6, 1923

that I last saw h alive on July 6, 1923

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. C. Campbell M. D.

, 19 23 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL July 9 1923

20 UNDERTAKER Margaret S. Flynn

ADDRESS 1422 Light

IMPORTANT: Physicians should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77366 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4 91-002 D77366

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 8 East Mulberry St. St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Lawlor

(Residence in Baltimore: No. 8 East Mulberry St. St.; (yrs. 43) mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. March (Month) ? (Day) 1843 (Year)

7-AGE. 80 yrs. 4 mos. ? ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE. (State or Country). Dublin, Ireland.

PARENTS.

10-NAME OF FATHER. Do not know.

11-BIRTHPLACE OF FATHER. (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Do not know

13-BIRTHPLACE OF MOTHER. (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Anna L. Lawlor

(Address) 8 East Mulberry St.

15- Filed JUL 9 - 1923 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 7. (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmon Edema

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

July 8 1923 (Coroner) (Address) 10 E Lanvale

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cemetery

DATE OF BURIAL. 7/10/23 19

20-UNDERTAKER. Henry W. Mears & Son

ADDRESS 805 N. Calvert St.

Use typewriter, if possible; if not, write plainly. Exact statement of OCCUPATION is necessary. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

(See affadivit over)

D77367

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77367

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Little Sisters of the Poor St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Penehaun

(a) Residence No. Preston & Caroy Sts St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married,~~ Widow Widowed, ~~or Divorced.~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John Penehan

6-DATE OF BIRTH (month, day and year) March ~~1855~~ 1862

7-AGE 60 61 yrs. mos. ds.

If LESS than 1 day, hrs. or mtn.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, Michael Briselin

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Bridget Gleason

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Sister Florence

(Address) Little Sisters of the Poor

15-

Filed JUL 9 - 1923 19 GG Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 7 23

17- I HEREBY CERTIFY, That I attended deceased from ..... 19.. to ..... 19.....

that I last saw h.. alive on July 1 1923

and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

Duration ..... yrs. ..... mos. ..... ds

CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. Warner M. D

July 7, 1923 (Address) 133 Riley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral — DATE OF BURIAL. July 9 1923

20-UNDERTAKER. H. C. Weidefeld — ADDRESS 914 Greenmount Ave

(Instructions on back of certificates. Statement of OCCUPATION is very important. See

Personally appeared before me this 11th day of
July 1923 Mr Joseph a Renehan son of
Mrs Mary C Renehan. Who made affadivit
that the age of his Mother should be
March - 1862 age 61-yrs-4 months.
instead of March 1855 - 68 yrs old.

Seal J. J. Renehan
Son

Seal George H Greve
Notary Public

septicus, etc. The concurrent) affection need
nt. Example: *Measles*
by ds.; Bronchopneu-

Never report mere
itions, such as "As-
y, symptomatic), "At-
, "Convulsions," "De-
ile," etc.), "Dropsy,"
ure," "Hemorrhage,"
"Old Age," "Shock,"
," when a definite dis-
s the cause. Always
g from child birth or
septicemia," "PUERP-
; cause for which sur-
taken. For VIOLENT
JURY and qualify as
CIDAL, or as *probably*
rmine definitely. Ex-
ng; Struck by railway
wound of head—homi-
acid—probably suicide.
s fracture of skull, and
tetanus) may be stated
story." (Recommenda-
of death approved by
of the American Med-

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urther Statements
cian.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77368

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77368

1553

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 625 W. Franklin ST.: 4 WARD)

2-FULL NAME Lloyd Price

(a) RESIDENCE. No. 1836 McCulloh St. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Price

6 DATE OF BIRTH (month, day, and year) Feb-7-1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
71	71	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler

(b) General nature of industry, business, or establishment in which employed (or employer) Daniel Baker

(c) Name of employer Daniel Baker

9 BIRTHPLACE (city or town) (State or country) Burnesville Montgomery Co. Md.

PARENTS

10 NAME OF FATHER William Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Burnesville Montgomery Co. Md.

12 MAIDEN NAME OF MOTHER Sarah Jordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Burnesville Mont. Co. Md.

14 Informant Mary Price
(Address) 1836 McCulloh St

15 Filed JUL 9 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8th 1923

17

I HEREBY CERTIFY, That I attended deceased from June 24, 1923, to July 8, 1923,

that I last saw h[illegible] alive on July 8, 1923,

and that death occurred, on the date stated above, at 9.10 A m.

The CAUSE OF DEATH* was as follows:

Septic Meningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore.

Did an operation precede death? Yes Date of June 25 23

Was there an autopsy? No.

What test confirmed diagnosis? Spinal Puncture.

(Signed) Frank A Pacenza M. D.

, 19 (Address) 625 W Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pt Lookout Funeral Co	7-11 1923

20 UNDERTAKER George T. A Gibson ADDRESS 573 Fawn St

IMPORTANT is very important. See instructions on back of certificates. It may be properly classified. Exact statement of OCCUPA- State

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 77369

CERTIFICATE OF DEATH.

34 D 77369

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Childrens Hospital School WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Katherine Linimer

(Residence in Baltimore: No. 827 S. Boulden St. Street)

(If less than 1 day, ... hrs. ... min. / 1 yr., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, August 28, 1919.
(Month) (Day) (Year)

7-AGE, 3 yrs. 10 mos. 11 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Child
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, William Linimer

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Margaret Cumberland

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S E Lenhard

(Address) Childrens Hosp School

15- JUL 9 1923

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 8, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from December 1922, to July 8 1923, that I saw h[er] alive on July 8 1923, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Pott's Disease - Progressive
Asthma

(Duration) 6 yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary) Mediastinal Abscess

(Duration) 6 yrs. 7 mos. 7 ds.

(Signed) Raymond E. Lenhard M. D.

July 8, 1923 (Address) Childrens Hosp School

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death 1 yr. 6 mos. 18 ds. In the State 3 yrs. 10 mos. 10 ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence 827 S. Boulden St

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Sacred Heart Cem	July 10, 1923.
20-UNDERTAKER	ADDRESS
Tilly & Zeile	403 S Wolfe

D77370

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77370

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. #8 N. Highland ave St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura V. Groves

(Residence in Baltimore: No. #8 N. Highland ave St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. Feb 12 1849
(Month) (Day) (Year)

7-AGE. 74 yrs. 4 mos. 19 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Md

PARENTS.

10-NAME OF FATHER. John Bourroo

11-BIRTHPLACE OF FATHER. (State or Country). Md

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F. Groves

(Address) 145 Lakewood ave

15-

Filed JUL 9 - 1923 192.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 8 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry.) find that said deceased came to.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs. .....mos. .....ds.

(Signed) Thos. B. Norton M. D.
(Coroner.)

July 8 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal, or Homicidal.

Bolts. Md

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Stone Chapel Cemetery July 10 1923

20-UNDERTAKER. ADDRESS

Chas. G. Black 742 W. North Ave

Md

If very important. See instructions on back of certificate. Certificate should be properly classified. Exact statement of OCCUPATION

Spec.—1-19-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77371

CERTIFICATE OF DEATH.

46 D77371

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 Remsen Md St., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Amelia Erlen

(a) RESIDENCE No. 24 So Fulton Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick E

6 DATE OF BIRTH (month, day, and year) Jan. 6 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Emil Wetzig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sue Fehn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Lena Eath

(Address) 521 Barnstead Ave

15 Filed JUL 9 - 1923 J. A. R. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1923

17 I HEREBY CERTIFY, That I attended deceased from June 9. 1923, to July 8. 1923, that I last saw h[illegible] alive on July 6. 1923, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 24 S. Fulton Ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. D. Wilson, M. D.

, 19 (Address) 33 S. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 10 1923

20 UNDERTAKER ADDRESS

Wm Cook Undertaking Co

IMPORTANT is very important. See instructions on back of certificates. Exact statement of OCCUPATIONS should state that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

Infant Mackey

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77372

CERTIFICATE OF DEATH.

113 D77372

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2402 Riverside Ave St. 12 WARD)

2-FULL NAME Infant Mackey

(a) RESIDENCE NO. 2702 Riverside Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Albert C Mackey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Emma Ewell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Albert C. Mackey

(Address) 2702 Riverside Ave

15 JUL 9 - 1923

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1923

17

I HEREBY CERTIFY, That I attended deceased from June 30 1923 to July 8 1923,

that I last saw him alive on July 8 1923,

and that death occurred, on the date stated above, at 11-P m.,

The CAUSE OF DEATH* was as follows:

Gastro intestinal trouble

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) M Bernard Ford, M. D.

7/9, 1923 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	July 10 1923

20 UNDERTAKER H. McCormick & Co. ADDRESS 502 E. Fayette

IMPORTANT is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77373

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D77373

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1431 W. Lafayette ave ST. 16 WARD)

2-FULL NAME James H. Colbert

(a) RESIDENCE. No. 1431 W. Lafayettave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude S. Colbert.

6 DATE OF BIRTH (month, day, and year) 10-16-'89

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Jeweler

(c) Name of employer Castlberg Baltimore Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Wm. J. Colbert

11 BIRTHPLACE OF FATHER (city or town) Bowie, (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Bolden

13 BIRTHPLACE OF MOTHER (city or town) Bowie, (State or country) Md.

14 Informant Delia Craig (Sister)
(Address) 1431 W. Lafayette ave.

15 JUL 9 - 1923 16 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-8- 1923

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1922, to July 8, 1923, that I last saw him alive on July 7, 1923, and that death occurred, on the date stated above, at 7.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) George C. Page, M. D.

, 19 (Address) 1720 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	July 11 1923

20 UNDERTAKER ADDRESS

Connie E. Wright 1364 Penna

Make as many as properly classified. Exact statement of OCCUPA-
ns on back of certificates. See instructions on

Cor.—1-12-23—M&T—100 Bks.

D77374

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

177-881 D77374

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1362 N. Stricker ST., 15 WARD)

2-FULL NAME Vashti E. Harris

(a) RESIDENCE No. 1362 N. Stricker ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) D.S.N. March 4, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	4	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Berry Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Eliz. Hunter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Elizabeth Harris
(Address) 1362 N. Stricker

15 Filed JUL 9 - 1923, 19... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Poisoning following the eating of fire-cracker paste (fireworks)

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Feeble-minded

(duration) 7 yrs. 4 mos. 3 ds.

(Signed) J. S. Newcomer, M. D.
(Coroner.)

July 9, 1923 (Address) 220 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn.	July 11 1923
20 UNDERTAKER Walter N. Lewis	ADDRESS 1300 Eutaw

Instructions: Fill in all items. Use ink. Write plainly. Be sure to state every fact very important. See instructions on back of certificate. Exact statement of OCCUPATION is properly classified. Do not abbreviate. Do not use ditto marks. Do not leave blanks. If unknown, state

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

144 D77375

D77375

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 9th (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Linda Carter

(a) RESIDENCE NO. 2635 Boone st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married 1895

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 28 Months 1 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Miss. Not known

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Linda Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Mrs. Carter

(Address): 2635 Boone St.

15 Filed JUL 9 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7 1923

17

I HEREBY CERTIFY, That I attended deceased from July 6, 1923, to July 7, 1923.

That I last saw h e alive on July 7, 1923

and that death occurred, on the date stated above, at 5-30 p m.

The CAUSE OF DEATH* was as follows:

Child Birth, transverse presentation placenta with Post-partum hemorrhage (duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Transverse presentation placenta & Hemorrhage (duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Wm. Carter, M. D.

19 (Address) 426 E 22 st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel — DATE OF BURIAL: July 9, 1923

20 UNDERTAKER: James H. Dennis — ADDRESS: 1317 Pine St

TION is very important. See Instructions on back of certificates. Exact statement of OCCUPA- at it may be properly classified. PHYSICIANS should state

Spec.—8-24-14—M. & T.—2000 Bks.

Francis E Brady.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77376 ✓ D77376

D77376
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

9

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 175 Spring ST.; 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Francis E Brady

(Residence in Baltimore: No. 175 Spring St. St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) S.

6-DATE OF BIRTH, July 15, 1[illegible]
(Month) (Day) (Year)

7-AGE, 7 yrs. 11 mos. 10 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, James E Brady

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary Fisher

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James E Brady

(Address) 175 S Spring St

15- JUL 9 - 1923 191.... D. A. W.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 9, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 8 1923, to July 9 1923, that I saw her alive on July 8 1923, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage due to Peritonitis

(Duration) ....yrs. ....mos. 12 hrs.

CONTRIBUTORY (Secondary) Peritonitis

(Duration) ....yrs. ....mos. 6 hrs.

(Signed) Ralph L Slaght M. D.

July 9, 1923 (Address) 26 E Preston

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL,
Holy Redeemer	July 12, 1923
20-UNDERTAKER, Clapp & Sumner	ADDRESS 1424 Bway

Fill out only on this copy of certificate.

If NATURE OF OCCUPATION is very

Spec- 12-23-21-E.B.R.S.—400 Bks.

D77377

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D77377

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Hooper

(a) Residence No. 404 Mott St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Black	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1874

7-AGE. 48 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Johnstown, N.Y.

PARENTS.

10-NAME OF FATHER. Theodore Miller

11-BIRTHPLACE OF FATHER (city or town) (State or Country). New York

12-MAIDEN NAME OF MOTHER. Martha Fitch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Johnstown, N.Y.

14- (Informant) Municipal Hospital Records

(Address)

15- Filed JUL 9 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 7, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 24 1923 to July 7 1923

that I last saw her alive on July 6 1923,

and that death occurred, on the date stated above, at 5:00 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (Degenerative)
Auricular Fibrillation
Myocardial Insufficiency

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) N. Goldsmith M. D

7-7-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Woodberry cemetery	July 8, 1923
20-UNDERTAKER.	ADDRESS.
Edward Bryon	631 Orleans st

Please answer ALL questions. Underline the words which describe the CAUSE OF DEATH. The accuracy of OCCUPATION is very important. See back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77378

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 129 D77378

1-PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Harlan

(a) RESIDENCE NO. Shipley Station, ST., WARD Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Annie Harlan

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records.
(Address)

15 JUL 9 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1923

17

I HEREBY CERTIFY, That I attended deceased from June 26, 1923, to July 6, 1923, that I last saw him alive on July 6, 1923 and that death occurred, on the date stated above, at 2:15 P.m.

The CAUSE OF DEATH* was as follows:

Uremia (Renal origin).

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of ——

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) B. M. Rhoads, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Furnace Branch A.A.Co	7/10/23

20 UNDERTAKER	ADDRESS
R. L. Parham	902 Leadenhall St

IMPORTANT. See instructions on back of certificates. So that it may be properly classified. Exact statement of OCCUPATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77379

CERTIFICATE OF DEATH.

D77379

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2412 E. Fayette ST., 6 WARD)

2-FULL NAME Dorothy Porter PORTER.

(a) RESIDENCE NO. 2412 E. Fayette ST., ... WARD ....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 16th 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	13	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Queens Anne Co. Md.

PARENTS

10 NAME OF FATHER: Ernest Porter

11 BIRTHPLACE OF FATHER (city or town) (State or country): St Michaels Maryland

12 MAIDEN NAME OF MOTHER: Mary A Corgane

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Mary A Porter (Address) 2412 E. Fayette

15 Filed ..... 19 ..... ROBERT R. KRAUTER Registrar

JUL 9 - 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1923

17

I HEREBY CERTIFY, That I attended deceased from May 6 1923, to July 7 1923.

that I last saw her alive on July 7 1923,

and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis. Pericarditis

(duration) .... yrs. 2 mos .... ds.

CONTRIBUTORY (Secondary) Rheumatic Fever

(duration) .... yrs. 2 mos. .... ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? .... Date of ....

Was there an autopsy? ....

What test confirmed diagnosis? ....

(Signed) Elijah J Russell, M. D.

, 19 (Address) 156 N Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: July 11 1923

20 UNDERTAKER: Fred'k Lassahn Sons — ADDRESS: Fulberton

TION is very important. See instructions on back of certificates. If may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Blks.

D77380

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77380

164

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 E. Preston St.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Hubbard

(a) RESIDENCE. NO. 1208 E Preston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of William H Hubbard

6 DATE OF BIRTH (month, day, and year) April 18th 1830

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	93	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbott Co Md

PARENTS

10 NAME OF FATHER Elisbury Kirby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbott Co Md

12 MAIDEN NAME OF MOTHER Ann M Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbott Co Md

14 Informant Emma L Miller

(Address) 1208 E Preston st

15 Filed JUL 9 - 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1923

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1923, to July 8, 1923, that I last saw her alive on July 7, 1923, and that death occurred, on the date stated above, at 4.55 A m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion of Lungs (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Herbert Knapp, M. D.

July 9 1923 (Address) 1216 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 10 1923

20 UNDERTAKER George Schilling & Sons ADDRESS 1116 E Monument St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77381

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D77381

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 E. 36th ST., 9 WARD)

2-FULL NAME Annie E. Bauer

(a) RESIDENCE No. 637 E. 36th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph F. Bauer

6 DATE OF BIRTH (month, day, and year) Dec 20-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Valentine Shepherd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Caroline Roder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Joseph F. Bauer (Address) 637 E. 36th St

15 Filed JUL 9 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar. 1 1923, to July 8 1923, that I last saw her alive on July 7. 1923 and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) F. Fehnagren, M. D.

July 8, 1923 (Address) 1106 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 11 1923

20 UNDERTAKER Henry Lutz ADDRESS 1203 N. Broadway

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- ...ICIANS should state ...ll terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77382

CERTIFICATE OF DEATH.

X 4 D77382

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital 14 WARD)

2-FULL NAME Mrs. Dorothea Sevy.

(a) RESIDENCE NO. 156 W. 77th St. ST., WARD New York, N.Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of David H Sevy.

6 DATE OF BIRTH (month, day, and year) August 6, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	11	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer) 031
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina.

PARENTS

10 NAME OF FATHER Isidor Leopold.

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Rachel Myers.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Hosp. Records
(Address)

15 Filed JUL 9 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1923.

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1923. to July 9, 1923. that I last saw her alive on July 9, 1923. and that death occurred, on the date stated above, at 1.35 P. m.

The CAUSE OF DEATH* was as follows:
Streptococcus viridans Septicaemia,
(origin unknown)

(duration) — yrs. — mos 5 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? New York City.

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Blood Culture.

(Signed) J. W. Thomas M.D. M. D.

1923 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York

DATE OF BURIAL 7/9/1923

UNDERTAKER David Sondheim

ADDRESS 118-20 W. Mt. Royal

TION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D77383

CERTIFICATE OF DEATH

74-001 ✓ D77383

REGISTERED NO. C.....

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1128 N Monroe ST.: 16 WARD)

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Hashagan

(Residence in Baltimore: No. 1128 N Monroe St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6-DATE OF BIRTH May (Month) 13th (Day), 1872 (Year)

7-AGE 51 yrs. 3 mos. ds. | If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Paper Carrier
(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore Sun Office

9-BIRTHPLACE (State or country) Baltimore Md

PARENTS

10-NAME OF FATHER Henry Hashagan

11-BIRTHPLACE OF FATHER (State or country) Germany

12-MAIDEN NAME OF MOTHER Augusta Eche

13-BIRTHPLACE OF MOTHER (State or country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Steinrich

(Address) 1128 N Monroe St

15-FILED JUL 9 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH July (Month) 7 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 7 (a.m.), 1923, to July 7 (1.15 p.m.) 1923, that I saw him alive on July 7 at 9 a.m. 1923, and that death occurred, on the date stated above, at 1.15 p.m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

12 hours.
(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY) Not Known

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. L. [illegible] M. D.

July 7, 1923 (Address) 2439 N Charles St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

	yrs.	mos.	ds.		yrs.	mos.	ds.
At place of death				In the State			

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL St Pauls Lutheran Cem — DATE OF BURIAL July 10 1923

20-UNDERTAKER Robert Brooks & Son — ADDRESS Calhoun Holl... St

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should supplied.

Spec- 12-23-21- E.B.R.S.-400 Bks.

D77384

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77384

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 4622 Greenmount St., ave 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kate Poisal (Poisal)

(a) Residence No. 4622 Greenmount St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 9 mos. 26 ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John N Poisal

6-DATE OF BIRTH (month, day and year) Sept 13-1851

7-AGE. 71 yrs. 9 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Wm Isaac Rhodes

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Calvert Co Md

12-MAIDEN NAME OF MOTHER, Margaret E Skinner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) J Wilson Poisal Jr

(Address) 4622 Greenmount Ave

15- Filed JULY 9 - 1923 ROBERT R. KRAMER, Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 8 1923

17- I HEREBY CERTIFY, That I attended deceased from Oct 15 1921 to July 8 1923

that I last saw h alive on July 7 1923

and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) 51 yrs. mos. ds.

CONTRIBUTORY (Secondary) Failure Compensation

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E Wallace Stevens M. D

(Address) 1238 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cem	July 10, 1923
20-UNDERTAKER,	ADDRESS
Robert Brooks & Son	Calhoun Hollins st

Instructions on back of certificates.

Please Statement of OCCUPATION is very important. See

Spec.—1-10-21—M&T—1500 Bks.

D77385

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 D77385

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2434 Madison Ave ST., 13 WARD)

2-FULL NAME Jennie Kaufman

(a) RESIDENCE No. 2434 Mad Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 17/1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boston Mass.

PARENTS

10 NAME OF FATHER Jacob Kaufman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fanie Ramsberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr H. Kaufman

(Address) 2434 Mad. Av.

15 Filed JUL 9 - 1923 ROBERT R. KRAUTZ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 5 1923 to July 8th 1923 that I last saw her alive on July 8th 1923 and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Rectum.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Asthenia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert L. Levy M. D.

19 (Address) 1235 E. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew — DATE OF BURIAL July 10th 1923

20 UNDERTAKER David Sondheim — ADDRESS 1811 N Broadway

THIS IS very important. See instructions on back of certificates. Exact statement of OCCUPATION that it may be properly classified. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77386

D77386

CERTIFICATE OF DEATH.

124

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 S. Broadway ST.: B WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Sands.

(a) RESIDENCE. NO. 218 S. Broadway ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Felix Sands

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper.

(b) General nature of industry, business, or establishment in which employed (or employer) Fine specialty

(c) Name of employer C. Tayette and Cachet

9 BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10 NAME OF FATHER — Macketosh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

11 Informant Felix Sands

(Address) 1816 Baker st.

JUL 9 - 1923

ROBERT P. KRAMER
Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1923

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1923, to July 7, 1923, that I last saw h[illegible] alive on July 7, 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis (Cruel) and Myo-carditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Joseph L. Valentine M. D.

July 9, 1923 (Address) 14 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	7/10 1923

20 UNDERTAKER Mrs E. A. Byrne ADDRESS 302 N. Gay St.

Important: See instructions on back of certificates. Exact statement of OCCUPA- ... properly classified. Should state

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-001 D77387

D77387

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 William ST., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara E Schwarz.

(a) RESIDENCE NO. 1114 William ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ferdinand Schwarz.

6 DATE OF BIRTH (month, day, and year) Feb 8 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

837

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Joseph Heck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Eckert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ferdinand Schwarz. (Address) 1114 William St

15 Filed JUL 9 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-7 1923

17 I HEREBY CERTIFY, That I attended deceased from 6-20, 1923, to 7-7, 1923, that I last saw her alive on 7-7, 1923, and that death occurred, on the date stated above, at 2:30 P m.

The CAUSE OF DEATH was as follows: Endophthalmic Sarcoma

(duration) yrs. 18 mos ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

*Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) James A Donnelly M. D.

7, 1923 (Address) 1076 West St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem Co — DATE OF BURIAL 7-10, 1923

20 UNDERTAKER E B Hale 115 — ADDRESS E Balto St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- be properly classified. ...ATIONS should state ...ever it may be ...

Spec.—1-10-21—M&T—1500 Bks.

D77388 HEALTH DEPARTMENT—CITY OF BALTIMORE D77388

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 321 S. Augusta St. (W) 20 WARD)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William L. Iser.

(a) RESIDENCE NO. 321 S. Augusta St. (W) WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. 7 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M. Elizabeth Taylor

6 DATE OF BIRTH (month, day, and year) Mar 1878

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
45	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Dalle Office Supply Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Chester Pa.

PARENTS

10 NAME OF FATHER Wm I Iser

11 BIRTHPLACE OF FATHER (city or town) (State or country) E Hartford Co Md

12 MAIDEN NAME OF MOTHER Anna M Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alsace Pa

14 Informant M. E. Iser (Address) 321 S Augusta St

15 Filed JUL 9 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1923

17 I HEREBY CERTIFY, That I attended deceased from July 5 1923 to July 8 1923, that I last saw h.. alive on July 8 1923, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Stevens J Cohen M. D.

7/8 1923 (Address) 20 W Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Allston Pa	July 10 1923

20 UNDERTAKER — ADDRESS

J B Hayward 2236 Fleet Ave

IMPORTANT is very important. See instructions that it may be properly classified. Exact statement of OCCUPATIONS on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Bks.

Theresa Drexel

D77389 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 74-001 ✓

D77389

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. Municipal Hospital St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Drexel

(a) Residence No. 202 Hayward Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): 1836

7-AGE. 86 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS

10-NAME OF FATHER: Charles Manstead

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Cecilia Hamell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-Informant: Municipal Hospital Records

(Address)

15-Filed JUL 9 - 1923 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 7, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 29, 19 23 to July 7, 19 23.

That I last saw her alive on July 7, 19 23,

and that death occurred, on the date stated above, at 11:50 P.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Wm. A. Fulton M. D.

7-9-, 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	7-10-1923

20-UNDERTAKER, H. McCauley Sons

ADDRESS 1111 Pennsylvania Ave

Attention is called to the reverse side of this blank for certificates.

Attention is called to the importance of OCCUPATION is very important. See

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77390

CERTIFICATE OF DEATH.

38 D77390

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Ebb

(a) Residence No. 585 Vincent St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1878

7-AGE. 44 yrs. mos. ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) St.Mary's Co.,Md.

PARENTS

10-NAME OF FATHER. Hanson Ebb

11-BIRTHPLACE OF FATHER (city or town) (State or Country) St.Mary's Co.,Md.

12-MAIDEN NAME OF MOTHER. Lillian Paffy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) St.Mary's Co.,Md.

11- (Informant) Municipal Hospital Records

(Address)

15- JUL 10 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 6, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 19, 1923 to July 6, 1923 that I last saw him alive on July 6, 1923 and that death occurred, on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia (Thrombosis) 6 W

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (Terminal) (Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. J. Fulton M. D

7-7-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Asbury	July 10th 1923

20-UNDERTAKER.	ADDRESS
Joseph A. Farrell	2319 Eutaw St

The Statement of OCCUPATION is very important. See reverse side on back of certificates.

REVISED

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Probable Cause

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77391

CERTIFICATE OF DEATH.

74-001

D77391

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 Ashland Ave 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa Gemmecker

(a) RESIDENCE NO. 1305 Ashland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Charles D. Gemmecker

6 DATE OF BIRTH (month, day, and year): July 19 1849

7 AGE: Years 75 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Henry Mattern

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Louisa Haas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles D. Gemmecker

(Address): 1305 Ashland ave

15 Filed JUL 10 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8 1923

17

I HEREBY CERTIFY, That I attended deceased from July 2 1923, to July 8 1923,

that I last saw h alive on July 7 1923,

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy, Left Hemiplegia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. B. Fink, M. D.

July, 19 23 (Address) 830 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem — DATE OF BURIAL: July 11 1923

20 UNDERTAKER: Frank A. Fink — ADDRESS: 915 N Eutaw

IT may be properly classified. Exact statement of OCCUPATION should state THION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

164836
D77392 Bm.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-002 D77392

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 6 REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Rosenblatt

(a) RESIDENCE NO. 413 N. Ann St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 26, 1923.

7 AGE — Years: — Months: 4½ Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER David Rosenblatt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia.

12 MAIDEN NAME OF MOTHER Rose Skein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia.

14 Informant: JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUL 10 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1923

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1923. to July 8 1923.

that I last saw him alive on July 8 1923

and that death occurred, on the date stated above, at 5 55 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery (bacillary) not typed

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) W. N. Weech M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel — DATE OF BURIAL: July 10 1923

20 UNDERTAKER: Pact Bros — ADDRESS: 1439 E. Balto

IMPORTANT is very important. See instructions on back of certificates. Exact statement of OCCUPATIONS should state what may be properly classified.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Rubin)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77393

D77393

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. ..... ST.: No WARD)

REGISTERED NO. 413

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Rubin

(a) RESIDENCE No. 4331 E Lombard ST., ... WARD. .....

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 6 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January - 1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Hyman Rubin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ella Bers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Levis 1439 E Baltimore St

JUL 10 1923

J. L. R. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1923

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1923, to July 9, 1923, that I last saw him alive on July 9, 1923, and that death occurred, on the date stated above, at 9:20 A m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Carbuncle of neck

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Laboratory

(Signed) I. Sadoff M. D.

7/9, 1923 Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: July 10 1923

20 UNDERTAKER: Jack Levis — ADDRESS: 1439 E Baltimore St

THIS IS very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified. Exact statement of OCCUPATION should state

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77394

CERTIFICATE OF DEATH.

44 D77394

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1703 Hope ST., 9th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Joseph Dempsey.

(a) RESIDENCE No. 1703 Hope St. ST., WARD 9th
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Dempsey.

6 DATE OF BIRTH (month, day, and year) July 1, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cutter-Able Body

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mr. Strobel 886

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Dempsey

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country) County Wexford

12 MAIDEN NAME OF MOTHER Catherine Gormley

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mary E Dempsey. (Address) 1703 Hope st.

15 Filed JUL 10 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/7 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 29. 1923. to July 7. 1923.

that I last saw him alive on July 7. 1923

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Stomach

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 23 23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F J Kirby M. D.

July 9. 1923 (Address) 110 E Lexington ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 11 1923

20 UNDERTAKER ADDRESS

George J. Ruth 1735 Hayford Ave

IMPORTANT: Physicians should state that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77395

CERTIFICATE OF DEATH.

D77395

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 Hanover ST., W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Archie J Bowen

(a) RESIDENCE NO. 518 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 28 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Archie N Bowen

11 BIRTHPLACE OF FATHER (city or town) Calvert Co (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah E. Fowler

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co (State or country) Md

14 Informant Mrs Archie N Bowen

(Address) 518 Hanover st

15 JUL 10 1923 J. K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1923

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1923, to July 10, 1923, that I last saw him alive on July 9, 1923, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Measles

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C Hamer, M. D.

, 19 (Address) 1215 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Paul Church Cemetery — DATE OF BURIAL July 12 1923

20 UNDERTAKER Calvert Co Md Undertaking Co — ADDRESS 715 Light St

John F Denny

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- may be properly classified.

Spec.—1-19-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77396

CERTIFICATE OF DEATH.

109-801

D77396

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1420 N. Gay ST., 8 WARD)

2-FULL NAME Martha E Gross

(a) RESIDENCE NO. 1420 N. Gay ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 31-1903

7 AGE. Years	Months	Days	If LESS than 1 day, hrs or min.
19	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer C & P. Co 186

9 BIRTHPLACE (city or town) (State or country) Washington D C

PARENTS

10 NAME OF FATHER William H Gross

11 BIRTHPLACE OF FATHER (city or town) Annapolis (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary McBrady

13 BIRTHPLACE OF MOTHER (city or town) Annapolis (State or country) Maryland

14 Informant Mr Wm H. Gross

(Address) 1420 N Gay st

15 Filed JUL 10 1923 19 J. A. K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1923

17 I HEREBY CERTIFY, That I attended deceased from JUNE 23. 1923. to JULY 8th. 1923.

that I last saw h[er] alive on July 8th. 1923.

and that death occurred, on the date stated above, at 3-10 a m.

The CAUSE OF DEATH* was as follows: Tonsillitis. Infected Left Tonsil

Endocarditis.

CONTRIBUTORY (Secondary) Endocarditis. (duration) yrs. 2 mos+ ds.

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of NO.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest C Lemert M. D.

JULY 9th 1923 (Address) 9 E Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Hill Center Cemetery md

20 UNDERTAKER Dispanto. John F Denny

DATE OF BURIAL July 11 1923

ADDRESS 715 E. Lo St

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- that it may be properly classified.

D77397

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D77397

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 218 N Fulton Ave ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Joseph Alfred Bargas

(Residence in Baltimore: No. 218 N Fulton Ave St.: 72 yrs. 11 mos. 23 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: July (Month) 16 (Day) 1850 (Year)

7 AGE: 72 yrs. 11 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Contractor
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore City Md

PARENTS

10 NAME OF FATHER: Joseph H. Bargas

11 BIRTHPLACE OF FATHER (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mrs. Carter

13 BIRTHPLACE OF MOTHER (State or country): Federalsburg Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. J. Parkhurst

(Address) 1410 Park Ave

15 Filed JUL 10 1923 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 9 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 1923, to July 9th 1923 that I saw him alive on July 9th, 1923 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart due to Mitral Insufficiency

(Duration) yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Alice S. Parkhurst M. D.

July 9, 1923 (Address) 1410 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Lorraine Cemetery

DATE OF BURIAL: July 11, 1923

20 UNDERTAKER: John F Denny

ADDRESS: 715 Light St

NAME CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D77398

HEALTH DEPARTMENT—CITY OF BALTIMORE D77398

CERTIFICATE OF DEATH.

143-002

1-PLACE OF DEATH: Ambulance en-route to

City of BALTIMORE: (No. St. Joseph's Hospital St. 26 Ward)

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Clara D.Leaverton

(Residence in Baltimore: No. 417 S. 13th St. Highlandtown St.; yrs. 20 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: May (Month) 28 (Day) 1889 (Year)

7-AGE: 34 yrs. 1 mos. 9 ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer): House-wife

9-BIRTHPLACE (State or Country): Northumberland Pa.

PARENTS

10-NAME OF FATHER: Levi E.Martz

11-BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12-MAIDEN NAME OF MOTHER: Ellen Spotts

13-BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen Martz(Mother)

(Address) 418 S. 13th St.Highlandtown

15 JUL 10 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July (Month) 7 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage in abdomen due to ruptured rt. fallopian tube - ectopic gestation- 3 mon gestation (Autopsy at hospital)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J.S.N. Cole M.D. M. D. (Coroner)

7/9/23 192 (Address) 508 E.North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Oak Lawn Cemetery DATE OF BURIAL: July 10. 1923

20-UNDERTAKER: John F Denny ADDRESS: 715 Light St

Is very important. See instructions on back of certificate. Exact statement of OCCUPATION is properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77399

CERTIFICATE OF DEATH.

90 ✓ D77399

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2842 N. Calvert ST., 17 WARD)

2-FULL NAME David James Hunter

(a) RESIDENCE NO. 2842 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Stinson Hunter

6 DATE OF BIRTH (month, day, and year) Nov 17th, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ..min.
	66	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer Penna R. R.

9 BIRTHPLACE (city or town) (State or country) Smyrna Delaware

PARENTS

10 NAME OF FATHER David Hunter

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Emma S Hunter

(Address) 2842 N. Calvert St

15 JUL 10 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9th, 1923

17

I HEREBY CERTIFY, That I attended deceased from July 15th, 1923, to July 9th, 1923, that I last saw him alive on 3 P.M. July 5th, 1923, and that death occurred, on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Heart Disease

(General Arterio Sclerosis with Myocarditis & Dilatation of Heart)

(duration) Many yrs. mos ds.

CONTRIBUTORY (Secondary) died Suddenly

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wilmer Brinton, M. D.

, 19 (Address) 1 W Cor. Calvert & Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetary	July 11 1923
20 UNDERTAKER	ADDRESS
Gutschlag	1723 W Fay

THON is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77400

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77400

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 438 E Biddle ST., 11 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J. Hess

(a) RESIDENCE NO. 438 E. Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Ed. E. Hess

6 DATE OF BIRTH (month, day, and year) Feb 21-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	60	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER William L. Appleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Sarah Laburton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant (Address) Mrs E E Hess 438 E Biddle St

15 Filed ....., 19.... Registrar

JUL 10 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9th 1923

17

I HEREBY CERTIFY, That I attended deceased from June 13th, 1923, to July 9th, 1923, that I last saw h[illegible] alive on July 8th 10.30 M, 1923, and that death occurred, on the date stated above, at 1.10 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with Cardiac Complications 1

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Colitis 1

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes Pathological Histological Exam

What test confirmed diagnosis?

(Signed) Wilmer Brinton, M. D.

, 19 (Address) 1. W Cor. Calvert & Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge DATE OF BURIAL July 11 1923

20 UNDERTAKER: A S Marshall ADDRESS 3539 Eutaw

THIS is very important. See instructions on back of certificates. ...that it may be properly classified. Exact statement of OCCUPATIONS should state

Spec.—8-24-14—M. & T.—2000 m.

D77401

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77401

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 N. Fulton Ave ST.; 20 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Susan Schaumbourg (Schoenbourg)

(Residence in Baltimore: No. Home for Aged of the M E Church (43) St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH, December 11, 1842
(Month) (Day) (Year)

7-AGE, 80 yrs. 6 mos. 25 ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Thomas M. Cox

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Mary Ann Shackelton

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. Wastendorf

(Address) 400 N. Fulton Ave

15-

Filed....., 191.....
Registrar.

JUL 10 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 7, 1923
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from May 28 1923, to July 7 1923, that I saw h er alive on July 7 1923., and that death occurred, on the date stated above, at 10 45 m.

The CAUSE OF DEATH* was as follows: See note on back

Diabetes Insipidus

(Duration) 2 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary) Toxaemia

(Duration) ✓ yrs. 7 mos. ✓ ds.

(Signed) George C. Shannon M. D.

7/10, 1923 (Address) 700 Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mount Olivet	July 11, 1923

20-UNDERTAKER	ADDRESS
George J. Smith	1537 Hollins

Fill out statement of OCCUPATION as given by informant. Sign name of certificate.

FILM

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77402

CERTIFICATE OF DEATH.

13. D77402

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. On way to University Hospital ST., 21 WARD)

2-FULL NAME Amelia Hall.

(a) RESIDENCE No. 744 Foundry Court. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... born
(b) General nature of Industry, business, or establishment in which employed (or employer) .....
(c) Name of employer —

9 BIRTHPLACE (city or town) ..... Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER Paul. Hall.

11 BIRTHPLACE OF FATHER (city or town) Balt.
(State or country)

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) Don't know
(State or country)

14 Informant Paul Hall
(Address) 744 Foundry Court

15 Filed JUL 10 1923 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Heat Prostration

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Gompf, M. D.
(Coroner.)

7-10- 1923 (Address) 117 N Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 11 1923
20 UNDERTAKER	ADDRESS
James Dignan & Son	1000 S. Pacast

(See instructions on back of certificate. Exact statement of OCCUPA-

S·A·F

KODAK

Spec– 12-23-21–E.B.R.S.–400 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77403

CERTIFICATE OF DEATH.

90 ✓ D77403

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 17 Ward) Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Smith

(a) Residence No. 318 22½ St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Black	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wife ?

6-DATE OF BIRTH (month, day and year) 1863

7-AGE. 60 yrs. — mos. — ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) House Work 17

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Frederick Co., Md.

PARENTS.

10-NAME OF FATHER, George Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Frederick Co., Md.

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Frederick Co.,

14- Municipal Hospital Records (Informant)

(Address).....

15- Filed JUL 10 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 7, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 26 1923 to July 7 1923.

that I last saw her alive on July 7 1923.

and that death occurred, on the date stated above, at 4:45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (Hyp...
Arterial Fibrillation
Myocardial Insufficiency
(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure
(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Wm. J. Fuller M. D.

7-7-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Laurel Cemetery	July 10 1923

20-UNDERTAKER.	ADDRESS.
Wm Robert Tittle & Son	725 Ashland Ave

Statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D77404

1-PLACE OF DEATH D77404

CITY OF BALTIMORE: (No. 203 Ostenberg St. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Johnson

(a) RESIDENCE NO. 203 Ostenberg ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 7, 1923

7 AGE Years Months Days If LESS than 1 day, 10 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

PARENTS

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER James Filoie

11 BIRTHPLACE OF FATHER (city or town) Charles
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Ella Johnson

13 BIRTHPLACE OF MOTHER (city or town) Charles
(State or country) North Carolina

14 Informant Ella Johnson (mother)
(Address) 203 Ostenberg St.

15 Filed JUL 10 1923, 19 ROBERT R. KRANTZ, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1923

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1923, to July 7, 1923, that I last saw h / alive on July 7, 1923 and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Rees, M. D.

7/9, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

UNIVERSITY OF MARYLAND — 19

20 UNDERTAKER — ADDRESS

Commissioner Health, JUL 10 1923

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

164063 D77405 ✓ 31 D77405

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 11

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Mary Parks

(a) RESIDENCE NO. 1130 McCulloh ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown mos. do. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 1

6 DATE OF BIRTH (month, day, and year) Jan 3-1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	2	6	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Fannie Parks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 JUL 10 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2nd 1923

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1923, to July 2nd, 1923, that I last saw h[illegible] alive on July 2nd, 1923, and that death occurred, on the date stated above, at 4-45 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of mediastinal lymph glands ?
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Miliary tuberculosis with the meningitis
(duration) yrs. mos. 19 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar puncture

(Signed) A. A. Veach M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JUL 12 1923

20 UNDERTAKER

ADDRESS

Registrar of Vital Statistics. JUL 10 1923

TION is very important. See Instructions on back of certificates. ...may be properly classified. Exact statement of OCCUPA-

Spec—12-23-21—E.B.R.S.—400 Bks.

D77406

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77406

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2530 Fleet St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie M. Peacock

(a) Residence No. 2530 Fleet St., 1 Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. — mos. — ds. How long in U. S., if of foreign birth? 17 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Marr

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Ben. Peacock

6-DATE OF BIRTH (month, day and year) April 5th 1802

7-AGE, 21 yrs. 3 mos. — ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Gone

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Norfolk Va

PARENTS.

10-NAME OF FATHER, David Savage

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Ella Simmons

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), City

14-

(Informant) Mr Ben Peacock

(Address) 2530 Fleet St

15- JUL 10 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 8, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 30, 1923 to July 8, 1923

that I last saw h-r alive on July 8, 1923

and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No.

What test confirmed diagnosis? Bacilli Demonstrated

(Signed) Allen E Buxton, M. D.

7-8-1923 (Address) 3139 E. Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Carmel DATE OF BURIAL, July 11, 1923

20-UNDERTAKER, Peter Nicolaus ADDRESS 2060 Eastern Ave

...ORTANT—Read carefully Rules and Directions on reverse side of certificate. Filling out of OCCUPATION is very important. See

Spec.—1-10-21—M&T—1500 Bks.

D77407 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-1001 ✓ D77407

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4611 Culver Ave ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Schneider

(a) RESIDENCE NO. 4611 Culver Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa Harris

6 DATE OF BIRTH (month, day, and year) May 1 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Henry W. Schneider (Address) 1509 E Baltimore

15 Filed JUL 10 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1923

17

I HEREBY CERTIFY, That I attended deceased from June 20, 1923, to July 9, 1923, that I last saw h alive on July 9, 1923, and that death occurred, on the date stated above, at 6-30 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Congestion

Myocardial Insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas Smith, M. D.

(Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Interment July 11 1923

20 UNDERTAKER Wm Cook 602 E. Balto Ave

ADDRESS

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. If not properly classified, it may be

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77408

CERTIFICATE OF DEATH.

44 D77408

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. 3040 Barclay ST., 12 WARD)

2-FULL NAME Patrick J. Hart

(a) RESIDENCE NO. 3040 Barclay ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. * mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Hart

6 DATE OF BIRTH (month, day, and year) March 9 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) Gen Co of P.

(c) Name of employer Washington D.C.

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary C. Hart

(Address) 3040 Barclay

15 Filed JUL 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1st 1923, to July 9th 1923, that I last saw h alive on ....., 19..., and that death occurred, on the date stated above, at 1215 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus of Stomach

Probably 4 mo

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of .....

Was there an autopsy?

What test confirmed diagnosis? X-Ray

(Signed) Thos. F. Ross, M. D.

....., 19... (Address) 2409 Md. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL July 11 1923

ADDRESS 502 E Nash

20 UNDERTAKER Wm Cook

TION is very important. See instructions on back of certificates. ...may be properly classified. Exact statement of OCCUPA-

Cor.—1-12-23—M&T—100 Bks.

Andrew J Bell

D77409

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77409

X 188-003

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME A J Bell

(a) RESIDENCE NO. 2 Hampstead ST., ... WARD Hampstead Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~2~~ yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Bell~~

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
72		~~1~~	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Jacobus Bell

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Dorothea Koge

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Edw C Talbert
(Address) Hampstead

15 Filed JUL 10 1923 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said ..... (Coroner, autopsy or Inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis 24 hours

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility Arterio

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W K Gorsuch, M. D.
(Coroner.)

7-10, 1923 (Address) Westminster

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arcadia Md	July 11 1923

20 UNDERTAKER	ADDRESS
Wm J Tickner & Son	North & Fremont Ave

Exact statement of OCCUPATION is properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D77410

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 43 D77410

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. Wilkens Ave. ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Giles

(a) RESIDENCE (Usual place of abode) No. 33 Oak St. Hornell, N. Y. ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? ? 73

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Foreman R.R.

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer

613

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER James P. Giles

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant John J. Barrett Jr

(Address) 422 Massachusetts Ave

15 Filed JUL 10 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1923

17

I HEREBY CERTIFY, That I attended deceased from 6/11, 1923, to 7/10, 1923,

that I last saw him alive on July 10th, 1923

and that death occurred, on the date stated above, at 12.55 p m.

The CAUSE OF DEATH* was as follows:

Cardiac failure following operation for carcinoma of lower lip.

Cardiac failure (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cancer of lip (duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6-20-23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. W. Scott, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hornell New York — DATE OF BURIAL: July 10 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Washington

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77411

CERTIFICATE OF DEATH.

3/, D77411

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Decker Randolph

(a) RESIDENCE NO. 55 N. Carolina st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1883 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Harrison Randolph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Branch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) M.T.H.

15 Filed JUL 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1923, to July 8, 1923, that I last saw h im alive on July 8, 1923, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis (duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Tuberculous pneumonia (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Frances L. Dalaglieu M. D.

7-9-23. (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Removed Samuel Cemetery — DATE OF BURIAL 1/11/23

20 UNDERTAKER Robert K. Williams — ADDRESS 1515 McCulloh St

TION is very important. See instructions on back of certificates. may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77412

CERTIFICATE OF DEATH.

X 101-80 ✓

D77412

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1041 Myrtle Ave ST., 17 WARD)

2-FULL NAME Stella A. Harris

(a) RESIDENCE NO. 1041 Myrtle Ave ST., WARD Virginia

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 8 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Douglas Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Jennie Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Jennie Harris (Address) 1041 Myrtle ave

15 JUL 10 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-7- 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 25th, 1923, to June 6th, 1923, that I last saw h[er] alive on June 6th, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos 6 ds.

CONTRIBUTORY (Secondary) Pneumonia (Lobar)

(duration) yrs. 1 mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of — .

Was there an autopsy? No

What test confirmed diagnosis? Usual tests for nephritis

(Signed) Jas C Poulson, M. D.

19 (Address) 1063 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 7-11 1923

20 UNDERTAKER Daniel Easton

ADDRESS 916 Penna ave

IMPORTANT may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Skelley.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77413

CERTIFICATE OF DEATH.

124 129

D77413

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1033 Riverside Ave ST., 24 WARD)

2-FULL NAME John M. Skelley.

(a) RESIDENCE NO. 1033 Riverside Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie F. Skelley

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O'H O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Skelley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Mary A Zeller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York Pa.

14 Informant Mrs Nellie F Skelley

(Address) 1033 Riverside Ave

15 JUL 10 1923 ROBERT R. KRAUTER, Registrar

Filed 19 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1923

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1923, to July 9, 1923, that I last saw him alive on July 9, 1923, and that death occurred, on the date stated above, at 6.15 a m.

The CAUSE OF DEATH* was as follows:

chronic interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Walter A Cole M. D.

, 19 (Address) 543 Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harmony Grove Md	7-11 1923
20 UNDERTAKER	ADDRESS
E & B Slater	112 E Read St

THIS is very important. See Instructions on back of certificates. Exact statement of OCCUPATION may be properly classified. Should state

Spec.—1-10-21—M&T—1500 Bks.

D77414

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D77414

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2842 Guilford Ave. ST., 17 WARD)

2-FULL NAME Joseph D. Delano

(a) RESIDENCE NO. 2842 Guilford Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~WIFE of~~ Ida Snyder Delano

6 DATE OF BIRTH (month, day, and year) Aug. 18. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	70	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Master Mariner

(b) General nature of industry, business, or establishment in which employed (or employer) Superintendant

(c) Name of employer Old Bay Line Steamboat Co.

9 BIRTHPLACE (city or town) Kent Co.

(State or country) Md.

PARENTS

10 NAME OF FATHER Carl Delano

11 BIRTHPLACE OF FATHER (city or town)

(State or country) France

12 MAIDEN NAME OF MOTHER Susanna Contress

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) France

14 Informant Mrs Ida S. Delano

(Address) 2842 Guilford Ave

15 FILED JUL 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8. 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to July 8, 1923, that I last saw him alive on July 7, 1923, and that death occurred, on the date stated above, at 3:10 A m.

The CAUSE OF DEATH* was as follows:

Cerebro-sclerosis (Coronary Disease)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. D. Zacharias M. D.

7/9/1923 (Address) 8 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: 7/10.23

20 UNDERTAKER: H.E. Hughes — ADDRESS: 424 N. Broadway

TION is very important See Instructions on back of certificates. ...that it may be properly classified. Exact statement of OCCUPA-

D77415

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. D77415

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 26 112 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Anderson

(Residence in Baltimore: No. 110 Patapsco Ave St. Helena St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	white	Single

6-DATE OF BIRTH. March 30 / 1920
(Month) (Day) (Year)

7-AGE. 3 yrs. 3 mos. 10 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Charles Anderson

11-BIRTHPLACE OF FATHER, (State or Country). Mmd.

12-MAIDEN NAME OF MOTHER. Grace Green

13-BIRTHPLACE OF MOTHER, (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Green

(Address) 110 Patapsco Ave

15- JUL 10 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 10/23, 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia- Acute indigestion- Histy of indiscretion in diet.
(Autopsy at hospital showed nothing)
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) J S H Ball M. D.
(Coroner.)
7/10/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death. yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Ebenezer Cemetery	July 10, 1923
20-UNDERTAKER. London Co Va	ADDRESS
John F Denny.	715 Light st

(If not in a hospital or institution, give STREET AND NUMBER. Exact statement of OCCUPATION is necessary. If DEATH WAS DUE TO EXTERNAL CAUSES, state MEANS OF INJURY, and whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. See instructions on back of certificate.)

Spec.—1-10-21—M&T—1500 Bks.

(Robert Wade)

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77416

CERTIFICATE OF DEATH.

7-10

D77416

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sykesville Hospital WARD) 23

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Robert Wade

(a) RESIDENCE NO. 3rd Ave + Marshall Rd ST., Brooklyn, Md. WARD

(Usual place of abode) (If not resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 26-1920

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Fred. Wade

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Alma Schoolman 7/10/23

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Hospital Records. (Address)

15 Filed JUL 10 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1923, to July 10, 1923, that I last saw him alive on July 10, 1923, and that death occurred, on the date stated above, at 5:40A m.

The CAUSE OF DEATH* was as follows:

Diphtheria, nasal, laryngeal + laryngeal.

(duration) — yrs. — mos 4 da.

CONTRIBUTORY (Secondary) Myocarditis

(duration) — yrs. — mos. 2-3 da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no Cultured (+)

What test confirmed diagnosis?

(Signed) B Macgowan, M. D.

(Address) Sykesville Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Holy Redeemer	July 11 1923
20 UNDERTAKER	ADDRESS
Geo M. Fink & Son	811 N Wolfe

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. Words "Laborer," "Housewife," "Clerk," "Student," "Retired," "Unemployed," "Child," "Infant," "Boy," "Girl," "Man," "Woman," "Widow," "Widower," "Unknown," "Unnamed," "Stillborn," "Died at birth," "Died in infancy," "Died in childhood," "Died in old age," "Died in hospital," "Died at home," "Died in transit," "Died in prison," "Died in asylum," "Died in workhouse," "Died in poorhouse," "Died in jail," "Died in penitentiary," "Died in reformatory," "Died in orphanage," "Died in foundling hospital," "Died in maternity hospital," "Died in lying-in hospital," "Died in charity hospital," "Died in public hospital," "Died in private hospital," "Died in sanitarium," "Died in convalescent home," "Died in nursing home," "Died in rest home," "Died in boarding house," "Died in hotel," "Died in apartment," "Died in tenement," "Died in flat," "Died in house," "Died in cottage," "Died in shack," "Died in hut," "Died in tent," "Died in camp," "Died in barracks," "Died in dormitory," "Died in monastery," "Died in convent," "Died in rectory," "Died in parsonage," "Died in manse," "Died in vicarage," "Died in deanery," "Died in bishop's palace," "Died in archbishop's palace," "Died in cardinal's palace," "Died in pope's palace," "Died in papal palace," "Died in papal residence," "Died in papal court," "Died in papal chapel," "Died in papal basilica," "Died in papal cathedral," "Died in papal church," "Died in papal monastery," "Died in papal convent," "Died in papal rectory," "Died in papal parsonage," "Died in papal manse," "Died in papal vicarage," "Died in papal deanery," "Died in papal bishop's palace," "Died in papal archbishop's palace," "Died in papal cardinal's palace," "Died in papal pope's palace," "Died in papal papal palace," "Died in papal papal residence," "Died in papal papal court," "Died in papal papal chapel," "Died in papal papal basilica," "Died in papal papal cathedral," "Died in papal papal church," "Died in papal papal monastery," "Died in papal papal convent," "Died in papal papal rectory," "Died in papal papal parsonage," "Died in papal papal manse," "Died in papal papal vicarage," "Died in papal papal deanery," "Died in papal papal bishop's palace," "Died in papal papal archbishop's palace," "Died in papal papal cardinal's palace," "Died in papal papal pope's palace," "Died in papal papal papal palace," "Died in papal papal papal residence," "Died in papal papal papal court," "Died in papal papal papal chapel," "Died in papal papal papal basilica," "Died in papal papal papal cathedral," "Died in papal papal papal church," "Died in papal papal papal monastery," "Died in papal papal papal convent," "Died in papal papal papal rectory," "Died in papal papal papal parsonage," "Died in papal papal papal manse," "Died in papal papal papal vicarage," "Died in papal papal papal deanery," "Died in papal papal papal bishop's palace," "Died in papal papal papal archbishop's palace," "Died in papal papal papal cardinal's palace," "Died in 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D77417

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1888-003 D77417

1-PLACE OF DEATH Franklin Sq Hospital

Registered No. C.....

City of BALTIMORE: (No. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Manuel Beverly

(Residence in Baltimore: No. 1035 W. Lexington St. St.; 2 1/2 yrs., ... mos., ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	Colored	single

6-DATE OF BIRTH. October 27, 1916
(Month) (Day) (Year)

7-AGE. 7 yrs. 10 mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... at school
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Washington, D.C.

PARENTS.

10-NAME OF FATHER. James A. Craven

11-BIRTHPLACE OF FATHER, (State or Country). North Carolina

12-MAIDEN NAME OF MOTHER. Nellie Beverly

13-BIRTHPLACE OF MOTHER, (State or Country). Bolden Green Carling Co. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Beverly

(Address) 1035 W. Lexington St.

15-

Filed JUL 11 1923 G.L. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 7- 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsies or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH was as follows:

In Auto. Accident
Multiple Fractures
Shock
(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Carlon Reed M. D.
(Coroner)
1923 (Address) 143 N. Gay

*State the Disease Causing Death, or, in deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn Cemetery	July 11, 1923.
20-UNDERTAKER.	ADDRESS 322
Mrs. Katie R. Williams	N. Schroeder St.

Cor.—1-12-23—M&T—100 Bks.

D77418 HEALTH DEPARTMENT—CITY OF BALTIMORE D77418

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 431 E. Fort Ave. ST. 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John E. Freeburger.

(a) RESIDENCE No. 431 E. Fort Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 4 mos. 17 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE OF~~ Clara D. Freeburger.

6 DATE OF BIRTH (month, day, and year) February 21, 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	50	4	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Captain, Tug Mary Clare.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer do

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John E. Freeburger.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Thereon.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Clara D. Freeburger. (wife). (Address) 431 E. Fort Ave.

15 Filed JUL 11 1923 GG Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (

(duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

July 9, 192 3 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..yrs., ..mos., ..ds. In the State ..yrs., ..mos., ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	July 11 1923
20 UNDERTAKER	ADDRESS
Margaret D. Flynn	1422 Light

HEALTH DEPARTMENT--CITY OF BALTIMORE

D77419

CERTIFICATE OF DEATH

D77419

1 PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No 1156 Longwood ST. 16 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Minnie Hilchick

(Residence in Baltimore: No. 1156 Longwood St.: 63 yrs. 9 mos. 3 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Widow.

6 DATE OF BIRTH: Oct (Month) 6 (Day), 1859 (Year)

7 AGE: 63 yrs. 9 mos. 3 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John S. Summerfield

11 BIRTHPLACE OF FATHER (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Stuck

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fritz Hilchick

(Address) 1156 Longwood St.

15.

Filed JUL 11 1923 GL REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July. (Month) 9 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6, 1923 to July 9 1923, that I saw h.. alive on July 9, 1923, and that death occurred, on the date stated above, at 4.35 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver, Intestines & Stomach

(Duration) 1 yrs. 8 mos. — ds

Contributory (SECONDARY) Exhaustion.

(Duration) — yrs. — mos. 2 ds.

(Signed) H. Hobart Keech M. D.

July 9, 1923 (Address) 219 W Eathom St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: London Park Cem. DATE OF BURIAL: June 12, 1923

20 UNDERTAKER: Jos Joerdens Son ADDRESS: 207 S. Paca

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77420

CERTIFICATE OF DEATH.

D77420

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 N Robinson ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Charlotte Mormann

(a) RESIDENCE NO. 502 N Robinson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of /

6 DATE OF BIRTH (month, day, and year): Nov 20, 1854 ~~July 9, 1923~~

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto City (State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) / (State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) / (State or country)

14 Informant Herman Tzeman (Address) 502 N Robinson St

15 JUL 11 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9 1923

17 I HEREBY CERTIFY, That I attended deceased from , 1921 , to July 9 , 1923, that I last saw her alive on July 9 , 1923, and that death occurred, on the date stated above, at 4.55 P m.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

from history (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H Grinhaus M. D.

July 10 1923 (Address) 3100 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

DATE OF BURIAL: July 11 1923

20 UNDERTAKER: John Ellenick

ADDRESS: 2017 Orleans

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D77421

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77421

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3022 Harford Road, 9th WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Bell Morrison

(a) RESIDENCE NO. 3022 Harford Road ST., 9th WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 15-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	51	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress 069

(b) General nature of industry, business, or establishment in which employed (or employer) Department store

(c) Name of employer O'neill Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Hugh A Morrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary Spicer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mary Morrison

(Address) 3022 Harford ave.

Filed JUL 11 1923

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1923

17 I HEREBY CERTIFY, That I attended deceased from July 4 1923 to July 9 1923, that I last saw her alive on July 9 1923, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Acute Cellulitis of face & neck 3 days & Chronic Interstitial Nephritis

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Nephritis & Infection of Acute

(duration) ? yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? at 3022 Harford ave

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. J. Carman, M. D.

7-9, 19 (Address) 1702 N Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	July 12 1923
UNDERTAKER	ADDRESS
Wm. C. Black	927 N. Broadway

Undertaker

PHYSICIANS should state plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Maben)

D77422 HEALTH DEPARTMENT—CITY OF BALTIMORE D77422

111-601

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Maryland General Hospital ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Maben

(a) RESIDENCE NO. 2003 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Lillian M. Maben

6 DATE OF BIRTH (month, day, and year) Dec. 10, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber 054

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Harry L. Black

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James A. Maben

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Carrie Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant W. J. Maben, Jr.

(Address)

15 Filed JUL 17 1923 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1923

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1923, to July 10, 1923.

that I last saw him alive on July 10, 1923

and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Gastro Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of June 25

Was there an autopsy? Yes

What test confirmed diagnosis? Clinically

(Signed) James H. Wilkerson M. D.

19 (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: July 12th 1923

20 UNDERTAKER: E. M. McConnick ADDRESS

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. So that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

D77423

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77423

CERTIFICATE OF DEATH.

175

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 W. Montgomery St. 22 WARD)

2-FULL NAME Mary Strutter

(a) RESIDENCE NO. 203 W. Montgomery ST., 22 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem. | 4 COLOR OR RACE Col. | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 89

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Daniel Strutter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Alice Scott (Address) 102 W. West St.

Filed JUL 11 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/8 1923

17 I HEREBY CERTIFY, That I attended deceased from 7/3 1923, to 7/10 1923

that I last saw h alive on 7 1923

and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Lyn Bowley M. D.

7/9, 1923 (Address) 908 D Sharp St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Mt. Auburn Cem — DATE OF BURIAL 7/11 1923

20 UNDERTAKER Samuel T. Kemsley — ADDRESS 1 N. Eutaw

IT may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77424

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D77424

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5218 York Road ST., 27 WARD)

2-FULL NAME Georgia Jemima Scott

(a) RESIDENCE NO. 5218 York Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: H. R. Scott

6 DATE OF BIRTH (month, day, and year): July 10 1850

7 AGE: Years 73 Months 0 Days 0 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): ~~Wales~~ Wales

PARENTS

10 NAME OF FATHER: E. Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wales

12 MAIDEN NAME OF MOTHER: Sarah Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): H. R. Scott 5218 York Road

15 Filed JUL 11 1923, 19 — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 10 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to July 10, 1923.

that I last saw h[er] alive on July 10, 1923.

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Chronic Interstitial Nephritis

(duration) 15 yrs. mos ds.

CONTRIBUTORY (Secondary) Senile Cardiac Debility

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Annual findings

(Signed) D. W. Bishop M. D.

July 11, 1923 (Address) 507 Sheridan Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: July 12 1923

20 UNDERTAKER: Wm. J. Buchanan Sons

ADDRESS: Norfolk Va

IRON is very important. See instructions on back of certificate.

Certificate may be properly classified. Exact statement of OCCUPATIONS should state

Spec.—1-10-21—M&T—1500 Blks.

D77425

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 ✓ D77425

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4511 Groveland Ave. ST. 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Esther N. Ball

(a) RESIDENCE NO. 4511 Groveland Ave ST.; WARD

(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: I. Sewell Ball

6 DATE OF BIRTH (month, day, and year): Dec. 15, 1845

7 AGE: Years 77 | Months 6 | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Stephen R. Haines

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: ? Cookson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mr. David F. Ball

(Address) 114 W. 58th St. New York City

15 Filed JUL 11 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9 1923

17 I HEREBY CERTIFY, That I attended deceased from 4 yrs. 19 to July 9, 1923.

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis B
4 yrs duration Fatal
1 cerebral hemorrhage
(duration) yrs. mos. 2 days

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted ~~if not~~ at place of death? Yes

Did an operation precede death? No Date of —

Was there an autopsy? No By whom

What test confirmed diagnosis?

(Signed) Henry Reisinger M.D.

7/10, 1923 (Address) 3902 Groveland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge | DATE OF BURIAL: July 11 1923

20 UNDERTAKER: W. M. Tuckey Sons | ADDRESS: Norfolk Va

IMPORTANT: Physicians should state what it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D77426

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77426

CERTIFICATE OF DEATH.

15 129

1-PLACE OF DEATH

City of BALTIMORE: (No. 1802 Clifton Ave St., 15 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter B. Ridgely

(a) Residence No. 1802 Clifton Ave St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche Ridgely

6-DATE OF BIRTH (month, day and year) Oct. 22. 1866

7-AGE. 56 yrs. 4 mos. 12 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 066

(b) General nature of Industry, business, or establishment in which employed (or employer) Poultry

(c) Name of employer Salesman

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Arthur P. Ridgely

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Selah Walters

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Blanche M. Ridgely

(Address) 1802 Clifton Ave

15- Filed JUL 11 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 9 1923

17- I HEREBY CERTIFY, That I attended deceased from 7/1/23 to 7/9/23 that I last saw him alive on 7/9/23 and that death occurred, on the date stated above, at 1430 p.m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(Duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. 3 mos. — ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm Thos Bryant M. D.

, 19 (Address) 1928 N. Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loraine Cemetery DATE OF BURIAL, July 12 1923

UNDERTAKER. Josiah Syfers ADDRESS 1605 W. North Ave

Exact statement of OCCUPATION is very important. See back of certificates.

D77427

D77427

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 Sterling ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mamie Harris

(a) RESIDENCE. NO. 824 Sterling ST., ... WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fe	B	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43			

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mrs. Robert G. Elliott

(Address) Ashland Ave.

Filed OCT 11 1923 H. A. Mc Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-10-1923

17

I HEREBY CERTIFY, That I attended deceased from July 6, 1923, to July 10, 1923, that I last saw h. alive on July 10, 1923 and that death occurred, on the date stated above, at 9 10 a. m.

The CAUSE OF DEATH* was as follows:

Ch- Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Gorman, M. D.

7/11, 1923 (Address) 733 Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	July 12 1923
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	1723 Ashland Ave

Important. See instructions on back of certificates. Exact statement of OCCUPATION should state properly classified. Exact statement of OCCUPATION should state

D77428 HEALTH DEPARTMENT—CITY OF BALTIMORE D77428

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. Md. Gen. Hosp. St. 13 Ward) 170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine E. Middleton

(Residence in Baltimore: No. 3406 Beech Ave. St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: July 14 (Month) (Day) 1876 (Year)

7-AGE: 46 yrs. 11 mos. 24 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS:

10-NAME OF FATHER: Howard Coe

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Mary J. Conway

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Coe

(Address) Waldorf Md.

15- Filed JUL 11 1923 G.S. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 9 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or Inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Wounds by gunshot
Wounds of Chest.

(Duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. A. O'Hennessy M. D. (Coroner)

July 10 1923 (Address) 218 Fremont Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Oakland Cem July 11 1923

20-UNDERTAKER. ADDRESS
Schumacher & Son Chestnut St

Any omission or improper classification of PHYSICIANS should be reported promptly. See instructions on back of certificate. Exact statement of OCCUPATION

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77429

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8 31 D77429

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1329 E. North ave (ST.) (WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Frisch

(a) RESIDENCE. No. 1329 E. North ave ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer): National Casket

(c) Name of employer: Co. Balto.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant (Address): Martha E. Frisch 1329 E. North ave

15 JUL 11 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1923

17

I HEREBY CERTIFY, That I attended deceased from June 10, 1923, to July 10, 1923

that I last saw him alive on July 10, 1923

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.

(Address) 1531 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 12 1923

20 UNDERTAKER: E. A. Wiedefeld Jr ADDRESS: 501 E 22 St

See instructions on back of certificates. Exact statement of OCCUPATIONS should state particularly important. Every item must be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

D77430 HEALTH DEPARTMENT—CITY OF BALTIMORE D77430

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Walbrook Apartments ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Gordon Seibold

(a) RESIDENCE NO. Walbrook Apartments ST., 15 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 61 yrs. 7 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of Cora Beatrice Seibold

6 DATE OF BIRTH (month, day, and year) Nov-30-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Traveling Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) of shoes for 066

(c) Name of employer Krohn Feckheimer Co.

9 BIRTHPLACE (city or town) (State or country) Wilmington Deleware

PARENTS

10 NAME OF FATHER Geo. W. Seibold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Louisa Gordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Davenport Iowa

14 Informant (Address) Mrs. Cora B. Seibold (Wife) Walbrook Apartments.

15 Filed JUL 11 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8th 1923.

17 I HEREBY CERTIFY, That I attended deceased from A.M. July 8th 1923 to P.M. July 8th 1923.

that I last saw him alive on July 8th 1923.

and that death occurred, on the date stated above, at 11.40 P. m.

The CAUSE OF DEATH* was as follows: Acute dilatation of heart following Chronic myocarditis & mitral regurgitation.

Acute condition (duration) — yrs. — mos 3/4 ds.

CONTRIBUTORY (Secondary) Chronic condit (duration) 10 yrs. or more.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Only general symptoms

(Signed) O. H. Hoffmann M. D.

7/10 1923 (Address) 3402 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL July-12 1923

20 UNDERTAKER STEWART & MOWEN COMPANY (William F. Moore.)

ADDRESS 106 W. North Ave.

IMPORTANT. See instructions on back of certificates. Unless properly classified, it may be impossible to find it in the future.

Spec.—5-19-13—M. & T.—500 Bks.

Hogan

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77431 — 56 — D77431

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Garrison Ave — REGISTERED NO. C

CITY OF BALTIMORE: (No. Our Lady of Blessed Sacrament — ST.; 23rd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Catherine Hogan

(Residence in Baltimore: No. 900 S Sharp St — St.: yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): single

6-DATE OF BIRTH: Dec 18th, 1921 (Month) (Day) (Year)

7-AGE: 1 yrs. 6 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Matthew M Hogan

11-BIRTHPLACE OF FATHER (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Anna E Eigeldinger

13-BIRTHPLACE OF MOTHER (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Matthew Hogan

(Address) 900 S Sharp St

15-

Filed JUL 11 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: July 10, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 6 1923, to July 10 1923, that I saw her alive on July 10 1923, and that death occurred, on the date stated above, at 11a. m.

The CAUSE OF DEATH* was as follows:

~~Marasmus~~

Rachitis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Marasmus

(Duration) 1 yrs. mos. ds.

(Signed) W. G. Queen M. D.

7/12 1923 (Address) 3501 Garrison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. 13 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Baltimore Cemetry — DATE OF BURIAL: July 13, 1923

20-UNDERTAKER: Bott Funeral Inc — ADDRESS 1442 N Broadway

Cause statement of OCCUPATION is very important. Omission of certificate.

Joseph Ziemnicki

HEALTH DEPARTMENT--CITY OF BALTIMORE

D77432 ✓ D77432

CERTIFICATE OF DEATH

101-001

D77432

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 6 North Clinton St. 16 WARD) REGISTERED No. C

2 FULL NAME Joseph Ziemnicki

(Residence in Baltimore: No. 6 No Clinton St Str. 20 yrs. mos. ds.)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word): Married

6 DATE OF BIRTH: Feb 19, 1865 (Month) (Day) (Year)

7 AGE: 58 yrs. 4 mos. 22 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): G

9 BIRTHPLACE (State or country): Poland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (State or country): Poland

12 MAIDEN NAME OF MOTHER: UnKnown

13 BIRTHPLACE OF MOTHER (State or country): Poland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Constance Ziolkowski

(Address) 6 N. Clinton Street

15 Filed JUL 11 1923, 191 ROBERT R. KRAUTER, Burial Permit Clerk. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1923, to July 11, 1923, that I saw him alive on July 11, 1923, and that death occurred, on the date stated above, at 9 m.

The CAUSE OF DEATH* was as follows:

Primary Pneumonia

(Duration) yrs. mos. 5 ds

Contributory (SECONDARY) Chronic Nephritis

(Duration) 3 yrs. mos. ds.

(Signed), J. W. Schlegeder M. D.

July 11, 1923 (Address) 330 E Madison

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Holy Rosary — DATE OF BURIAL: July 13 1923

20 UNDERTAKER: JOHN M. WEBER — ADDRESS: 1803 BANK ST.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks. Frank Ambrozewicz

D77433

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D77433

1-PLACE OF DEATH 2010 Monmonier Court

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2010 Monmonier ST. WARD)

2-FULL NAME Frank Ambrozewicz

(a) RESIDENCE. No. 2010 Monmonier ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Joseph Ambrozewicz

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Anastasia Majerowicz

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Joseph Ambrozewicz
(Address) 2010 Monmonier Court

15 Filed JULY 1 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-10 1923

17 I HEREBY CERTIFY, That I attended deceased from 7-7- 1923, to 7-10 1923, that I last saw h[illegible] alive on 7-10 1923 and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Ulcerative Colitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

7-10-1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	July 12 1923

20 UNDERTAKER John M. Weber 1803 ADDRESS Bank Str

This is very important. See instructions on back of certificates. Every question must be properly classified. Exact statement of OCCUPATIONS should state

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77434

D77434

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 708 (St.) Arlington Ave (Ward) Evans

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen E. Hooper

(a) RESIDENCE NO. 708 (St.) Arlington Ave (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jeneus B. Hooper

6 DATE OF BIRTH (month, day, and year): ? ? ?

7 AGE: Years: about 59; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Ellen Hollins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Mary H. Hooper

(Address) 708 Arlington Ave

15 Filed JUL 11 1923, 19 ROBERT R. KRAUTER, Register

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 10 1923

17

I HEREBY CERTIFY, That I attended deceased from July 10th, 1923, to July 10, 1923, that I last saw her alive on July 10, 1923, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Haemaplegia of right side

0032

(duration) yrs. mos 2 hours, ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. L. Duncan, M. D.

July 11, 1923 (Address) 5104 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 7/13 1923

UNDERTAKER: William Cook — ADDRESS: 502 E North

IMPORTANT. See instructions on back of certificate. Exact statement of OCCUPATION is very important. Unless the following items are correctly answered, so that it may be properly classified.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso'n

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77435 CERTIFICATE OF DEATH. 100-801 ✓

REGISTERED NO. D77435

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Freeman

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address) UNIVERSITY OF MARYLAND.

15 JUL 11 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1923

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1923 to July 8, 1923, that I last saw him alive on July 8, 1923, and that death occurred, on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Terminal) Bronco-Pneumonia (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Feldman M. D.

7-9-1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health. JUL 11 1923

TION is very important. See instructions on back of certificates.

it may be properly classified. Exact statement of OCCUPA-

PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH D77436 REGISTERED No. D77436

CITY OF BALTIMORE: (No. 8 N Luzerne Av ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Herbert

(a) RESIDENCE NO. 8 N Luzerne ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 9-1920.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER John T Herbert

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Nellie Hopper

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant John T Herbert
(Address) 8 N Luzerne

15 Filed JUL 11 1923 ROBERT R. KRAETER, Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1923. to July 9, 1923.

that I last saw living alive on July 9, 1923

and that death occurred, on the date stated above, at 1.05 P. m.

The CAUSE OF DEATH* was as follows:

6 months

Marasmus

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos J. Jarvis, M. D.

July 9, 1923 (Address) 2816 Harford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	JUL 10 1923

20 UNDERTAKER Commissioner of Health

ADDRESS

TION is very important. See instructions on back of certificates.

Exact statement of OCCUPA-

that it may be properly classified.

PHYSICIANS should state

KODAK S·A·F

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77437

CERTIFICATE OF DEATH.

161-001 D77437

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 N. Luzerne ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Herbert

(a) RESIDENCE No. 8 N Luzerne ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 3 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant fed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER John T Herbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Nellie Hopper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md

14 Informant (Address) John T Herbert 8 N Luzerne

15 Filed JUL 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1923, to July 9, 1923, that I last saw him alive on July 9, 1923, and that death occurred, on the date stated above, at 1.15 p. m.

The CAUSE OF DEATH* was as follows:

6 Months Prematurity

(duration) * yrs. mos. ds.

CONTRIBUTORY (Secondary) 5 minutes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos Fa Stevens M. D.

7/9, 1923 (Address) 2878 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 10 1923

20 UNDERTAKER Commissioner Health.

ADDRESS

TION is very important. See Instructions on back of certificates. ...ate may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

D77438

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 D77438

1-PLACE OF DEATH — Belair Rd — REGISTERED NO.

CITY OF BALTIMORE: (No. 37 Woodlea Ave ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Springer

(a) RESIDENCE NO. 37 Woodlea Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 2 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced (or) WIFE of: late Lillian B. Springer

6 DATE OF BIRTH (month, day, and year): Apr 27/62

7 AGE: Years 60 Months 2 Days 12 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): 009

(c) Name of employer: Neudecker & Co.

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Valentine Springer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs F. M. Neudecker

(Address) 37 Woodlea Av

15 Filed JUL 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8 1923

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1923, to July 8, 1923

that I last saw h alive on 19

and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows: Pulmonary Phthisis

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. D. Connor, M. D.

, 19 (Address) Southern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 7/12 1923

20 UNDERTAKER: Philip Herring — ADDRESS 2016 Arlington,

IMPORTANT: Physicians should state terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77439

CERTIFICATE OF DEATH.

105 D77439

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 Decatur St. ST., 24 WARD)

2-FULL NAME Emily M.Voelkel,

(a) RESIDENCE NO. 1428 Decatur ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) June 2, 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	1	8.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Robert Voelkel.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Emily Pramschufer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Emily Voelkel. (mother).
(Address) 1428 Decatur St.

15 Filed JUL 11 1923 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastritis.
Acute Cardiac Dilatation.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt (Coroner.) M. D.

July 10, 1923. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL July 13 1923

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans st

Misc. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77440 CERTIFICATE OF DEATH. 162 D72889

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1807 Gough ST. W WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Orth

(a) RESIDENCE. NO. 1807 Gough ST. ..... WARD. .....

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 10, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 10 min.
		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER George Orth

11 BIRTHPLACE OF FATHER (city or town) Balto, Md
(State or country)

12 MAIDEN NAME OF MOTHER Barbara Schmidt

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Father Geo. Orth
(Address) 1807 Gough

15 JUL 11 1923 ROBERT R. KRAUTER,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 23.

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1923, to July 10, 1923, that I last saw her alive on July 10, 1923, and that death occurred, on the date stated above, at 12:25 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neo
(Umbilical Cord about neck)

(duration) — yrs. — mos. — ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Brad B Fanning Co. M. D.

July 10, 1923 (Address) 2002 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	July 10 1923
20 UNDERTAKER Lilly and Zeile	ADDRESS 403 S. Monroe St.

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATIONS should state what may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77441

CERTIFICATE OF DEATH.

74-001

D77441

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 819 N. Fulton Ave ST., 16 WARD)

2-FULL NAME Franklin A. Zumstein

(a) RESIDENCE NO. 819 N. Fulton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Wht.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Zumstein

6 DATE OF BIRTH (month, day, and year) Oct 28 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 809

(b) General nature of industry, business, or establishment in which employed (or employer) Express Co

(c) Name of employer American Railway Express

PARENTS

9 BIRTHPLACE (city or town) Frederick (State or country) Maryland

10 NAME OF FATHER Frederick Zumstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catharine Brengle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Sarah Zumstein (Address) 819 N Fulton Ave.

15 Filed JUL 11 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 19 23

17

I HEREBY CERTIFY, That I attended deceased from July 7, 19 23, to July 9, 19 23, that I last saw h alive on July 9, 19 23, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) C. B. Jones M. D.

7/11, 19 23 (Address) 720 N. Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	July 12 1923
UNDERTAKER	ADDRESS
Joseph B Cook	1003 W Balto St

IMPORTANT. PHYSICIANS should state so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Morgan

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77442

CERTIFICATE OF DEATH

47 D77442

1-PLACE OF DEATH University Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lombard & Green ST., 12 WARD)

2-FULL NAME Mrs Annie C. Morgan

(a) RESIDENCE No. 2 E 23rd ST. ..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced (or) WIFE of: Thomas Elliott Morgan

6 DATE OF BIRTH (month, day, and year): Jan. 22, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63 yrs	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School teacher

(b) General nature of industry, business, or establishment in which employed (or employer): 068

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Joseph F. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Elizabeth Ballard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Miss Emma Morgan
(Address) 2 E 23rd St.

15 JUL 11 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-11 1923

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1923, to July 11, 1923

that I last saw her alive on July 11, 1923

and that death occurred, on the date stated above, at 8:10 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency
Operative shock

(duration) ..... yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Carcinomatosis Both Breasts

Diabetes mellitus (duration) ? yrs. ? mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 7-10-23

Was there an autopsy? no

What test confirmed diagnosis? Clinical picture

(Signed) R. Dorsey Heuler, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Aberdeen Md

DATE OF BURIAL: July 13

UNDERTAKER: John O. Mitchell

ADDRESS: 1201 N. Fayette

THIS IS very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified. If PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

D77443

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 D77443

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 944 Harford Ave. ST., 10 WARD)

2-FULL NAME Mary. M. Uhl

(a) RESIDENCE NO. 944 Harford Ave. ST., 10 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 60 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles. F. Uhl

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	72	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Mr. Charles. F. Uhl No. 944 Harford Ave.

15 Filed JUL 12 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-11-1923

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1923, to July 10, 19 23, that I last saw h alive on July 10, 19.., and that death occurred, on the date stated above, at 2:10 A. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Some years (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Heart Failure (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? all

(Signed) W F. Riley M. D.

July 11 1923 (Address) 1089 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Ignatius Church Cemetery Hickory Harford Co. Md. DATE OF BURIAL July 13 1923

20 UNDERTAKER Henry Hoeck & Son ADDRESS 1301 E Eager St

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified. PHYSICIANS should state

Spec—12-23-21—E.B.R.S.—400 Bks.

D77444

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164 D77444

Registered No.....

1-PLACE OF DEATH 1326 W. Lombard

City of BALTIMORE: (No.....St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M Crawford

(a) Residence No. 1326 W Lombard St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 89 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) JUNE 23 1834

7-AGE 89 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work HOUSE WORK

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), BALTIMORE Md

PARENTS.

10-NAME OF FATHER, Jacob Crawford

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Carroll Co Md

12-MAIDEN NAME OF MOTHER, Sophia Abell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), St Marys Co Md

11- (Informant) Dorothy Tibbell

(Address) 1326 W. Lombard St.

15- Filed JUL 12 1923 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 10 1923

17- I HEREBY CERTIFY, That I attended deceased from July 1st 1923 to July 10th 1923

that I last saw her alive on July 7 1923,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Infirmities of age

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Marshall G. Smith M. D

July 11, 1923 (Address) 118 N Calhoun St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL BALTIMORE CEMETRY

DATE OF BURIAL. JULY 13 1923

20-UNDERTAKER. ROBERT BROOKS SON

ADDRESS 508 CALHOUN HOLLINS ST

Attention of OCCUPATION is very important. See back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Bks.

D77445

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77445

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 272 Loudon Av. 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Smith

(a) Residence No. 272 Loudon Av. St., Ward.....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. MALE

4-COLOR OR RACE, WHITE

5-~~Single~~, ~~Married~~ Widowed, ~~or Divorced.~~ (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) MARCH 15TH 1841

7-AGE. 82 yrs. ....mos. ....ds.

If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work TINNER

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), BALTIO CO

PARENTS.

10-NAME OF FATHER, JESSIE SMITH

11-BIRTHPLACE OF FATHER (city or town) (State or Country), BALTIO CO

12-MAIDEN NAME OF MOTHER, DELA HUDSON

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), BALTIO

14- (Informant) FRANCES MAGILL

(Address) 1723 EDMONSON AVE

15-

Filed JUL 12 1923 192.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 10-1923

17- I HEREBY CERTIFY, That I attended deceased from July 3 1923 to July 10 1923

That I last saw him alive on July 10 1923

and that death occurred, on the date stated above, at 12.25 PM

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arterial Sclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard W Jones M. D

July 10 1923 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
LOUDON PARK	JULY 12 1923
20-UNDERTAKER. ROBERT L BROOKS SON	ADDRESS CALHOUN & HOLLINS ST

See back of certificates.

Statement of OCCUPATION is very important.

Spec—12-23-21—E.B.R.S.—400 Eks.

Wilchuwski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77446 | 24 D77446

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Agnes Wilchiwski

(a) Residence No. 1011 Granby St. St., Ward A # 6
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, ~~Married~~ Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced ~~HUSBAND~~ of (or) ~~WIFE~~ of Joseph Wilchuwsky

6-DATE OF BIRTH (month, day and year) 1880

7-AGE, 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED 037

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Lithuania

PARENTS.

10-NAME OF FATHER, Martin Povlawitz

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Lithuania

12-MAIDEN NAME OF MOTHER, Mary

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Lithuania

14-(Informant) Hospital Record.

(Address).....

15-[illegible] JUL 12 1923 L. K. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 11-1923

17- I HEREBY CERTIFY, That I attended deceased from July 7, 1923, to July 11, 1923, that I last saw h— alive on July 11, 1923, and that death occurred, on the date stated above, at 12.25 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) K. W. Holley M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	July 13, 1923
20-UNDERTAKER.	ADDRESS
John Grebliunas	935 S Pa

Exact statement of OCCUPATION is very important. See back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77447

CERTIFICATE OF DEATH.

40 D77447

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 702 Carwell St. Ave Ward 23)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Goldie Fisher

(a) Residence No. 702 Carwell Ave St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 3 1893

7-AGE. 30 yrs. 6 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Mill Hand
(b) General nature of industry, business, or establishment in which employed (or employer) Mfg
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Md

PARENTS.

10-NAME OF FATHER James H Fisher

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Ellie Cornbower

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-(Informant) James H Fisher

(Address) 702 Carwell Ave

15-DATE RECEIVED JUL 12 1923

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 11 1923

17-I HEREBY CERTIFY, That I attended deceased from Oct 10 1922 to July 11 1923

that I last saw h alive on July 11 1923

and that death occurred, on the date stated above, at 5-15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma uteri ot Rectum.

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) unknown

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopical

(Signed) S R Wantz M. D.

July 11 1923 (Address) 865 W. 36th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Marys Hampden DATE OF BURIAL. July 14 1923

20-UNDERTAKER. ADDRESS

STENGWETH & SON
2627 CHESTNUT AVE.

Sheet Statement of OCCUPATION is very important. See back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77448

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 D77448

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1801 N. Chester ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jeceliu

(a) RESIDENCE No. 1801 N. Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John

6 DATE OF BIRTH (month, day, and year) Sept. 6, 1864

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Bohemia (State or country) Europe

PARENTS

10 NAME OF FATHER Louis Dobihal

11 BIRTHPLACE OF FATHER (city or town) Bohemia (State or country) Europe

12 MAIDEN NAME OF MOTHER Anna Dobihal

13 BIRTHPLACE OF MOTHER (city or town) Bohemia (State or country) Europe

14 Informant John Jeceliu (Address) 1801 N. Chester St.

15 Filed JUL 12 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1923

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to July 11, 1923,

that I last saw him alive on July 9, 1923,

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder 7

Exhaustion

(duration) yrs. 7 mos. 3 ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) yrs. 7 mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) O. B. Eaman, M. D.

7-11, 1923 (Address) 170 1 N Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakhill — DATE OF BURIAL July 13 1923

UNDERTAKER Junkin & Junkin — ADDRESS 1734 Eager

TION is very important. See Instructions that it may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77449 D77449

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital 14 X 34

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Jessie Ellsworth Michael

(a) RESIDENCE NO. ..... Westernport, Maryland ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 10 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs J. E. Michael

6 DATE OF BIRTH (month, day, and year) May 16th 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... mail-carrier

(b) General nature of industry, business, or establishment in which employed (or employer) ..... —

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) maryland

PARENTS

10 NAME OF FATHER George S. Michael

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) maryland

12 MAIDEN NAME OF MOTHER Rebecca Jenkins

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) maryland

14 Informant Union Memorial (Address) Baltimore Md

15 FILED JUL 12 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 2nd, 1923, to July 11th, 1923, that I last saw him alive on July 11th, 1923, and that death occurred, on the date stated above, at 5 15 P. m.

The CAUSE OF DEATH* was as follows:

Pott's disease (Tuberculosis) Thoracic — Lumbar spine, & destruction 5 vertebrae

(duration) about 11 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Terminal broncho-pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of May 15th 1923.

Was there an autopsy? no

What test confirmed diagnosis? Operation & X-rays.

(Signed) Jno. T. Hungerford Jr., M. D.

July 11th, 1923 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Piedmont, W. Va. — DATE OF BURIAL July 12 1923

20 UNDERTAKER Geckler & Geckler — ADDRESS 1739 Eager

IMPORTANT: Physicians should state carefully and correctly all items, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77450

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D77450

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2424 E Federal ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Hofferbert

(a) RESIDENCE NO. 2424 E Federal ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? 44 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth L Hofferbert

6 DATE OF BIRTH (month, day, and year) Nov 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	—	—	

8 OCCUPATION OF DECEASED 080

(a) Trade, profession or particular kind of work Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) Cutter for Tailoring Establishment

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth L Hofferbert (Address) 2424 E Federal

15 Filed JUL 12 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1923.

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1924, to July 9, 1923, that I last saw him alive on July 9, 1923, and that death occurred, on the date stated above, at abt 9 A. m.

The CAUSE OF DEATH* was as follows:

acute disappearance

Chr. interstitial nephritis

(duration) Abual yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. / mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of /

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms. Bl. N.P.N.

(Signed) Jno A Hutcheson M. D.

July 11, 1923 (Address) 1025 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Co. Pa. DATE OF BURIAL July 13 1923

20 UNDERTAKER Robt F Turner Inc 4 Broadway ADDRESS 1414

IMPORTANT. This certificate may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Farman A Sadler

D77451

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77451

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Edmondson Ave at 19th ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Farman A Sadler

(a) RESIDENCE No. Edmondson Ave & 19th ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lockport New York

PARENTS

10 NAME OF FATHER Warren H. Sadler

11 BIRTHPLACE OF FATHER (city or town) Lockport (State or country) New York

12 MAIDEN NAME OF MOTHER Letitia Elliott

13 BIRTHPLACE OF MOTHER (city or town) Medina (State or country) New York

14 Informant Mrs Edgar B. Browning

(Address) Edmondson ave at 19th St.

15 Filed JUL 12 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1923

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1923, to July 10, 1923, that I last saw h alive on July 10, 1923 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver
Involving Pylorus
and Gallbladder

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) John H Grant M. D.

, 1923 (Address) 101 N. Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Loudon Park Cemetery July 13 1923

20 UNDERTAKER — ADDRESS

Chas. G. Black 742 W. North ave

FION is very important. See instructions on back of certificates. Exact statement of OCCUPA- that it may be properly classified. PHYSICIANS should state terms, so that it

D77452 HEALTH DEPARTMENT—CITY OF BALTIMORE D77452

CERTIFICATE OF DEATH.

27 74-001

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 507 Arlington Ave. Govsns Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Bowen

(Residence in Baltimore: No. 507 Arlington Ave. St.; 4 yrs. ' mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
male	white	married

6-DATE OF BIRTH. Dec 19/1863 1.....
(Month) (Day) (Year)

7-AGE. 59 yrs. 7 mos. 21 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of Industry, business, or establishment in which employed (or employer): 05

9-BIRTHPLACE. (State or Country). Towson Md.

PARENTS:

10-NAME OF FATHER. Sylvester Bowen

11-BIRTHPLACE OF FATHER. (State or Country). Towson Md.

12-MAIDEN NAME OF MOTHER. Mary Langley

13-BIRTHPLACE OF MOTHER. (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Laura J. Bowen

(Address) 507 Arlington Ave.

15- Filed JUL 12 1923 192 H. Lane Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 9/23 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy-Chronic Nephritis-
Arteriosclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. S. Bowen M. D.
(Coroner.)

7/10/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Prospect Hill Cemetery Towson Md July 12 1923

20-UNDERTAKER. ADDRESS
Chas. E. Black 742 Westforth ave

See instructions on back of certificate. Exact statement of OCCUPATION should be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

D77453 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77453

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A. Kelly Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Edward Gottesman

(a) RESIDENCE No. Brownsville ST., WARD Pennsylvania
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel Gottesman

6 DATE OF BIRTH (month, day, and year) July 5th 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Provisions

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer Groceries

9 BIRTHPLACE (city or town) (State or country) Austria Hungary

PARENTS

10 NAME OF FATHER Herman Gottesman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria Hungary

12 MAIDEN NAME OF MOTHER Ester Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria Hungary

14 Informant Hospital Records (Address) Kelly's Baltimore

15 Filed JUL 12 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/11/1923

17 I HEREBY CERTIFY, That I attended deceased from July 8. 1923. to July 11. 1923.

that I last saw him alive on July 11. 1923.

and that death occurred, on the date stated above, at 9 50 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach with metastasis to liver

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Brownsville, Pa

Did an operation precede death? Yes Date of July 1922

Was there an autopsy? No.

What test confirmed diagnosis? Biopsy

(Signed) Robert E. Fricke, M. D.

, 19 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brownsville Pa	July 12 1923

20 UNDERTAKER	ADDRESS
Hart Goodheim	1180 W. Royal

IF IT may be properly classified. PHYSICIANS should state Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77454

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77454

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4511 Reisertown Rd ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Loretta Inc Shane

(a) RESIDENCE NO. 4511 Reisertown ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 20 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	43	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper 008

(b) General nature of industry, business, or establishment in which employed (or employer) U S Rubber Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Dr. James F. Mc Shane

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Sarah Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Mrs Charles Forbes

(Address) 4511 Reisertown Rd

15 Filed JUL 12 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1923

17

I HEREBY CERTIFY, That I attended deceased from July 5 1923 to July 10 1923.

that I last saw her alive on July 10 1923,

and that death occurred, on the date stated above, at 12.15 m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis 007

(duration) yrs. ... mos 5 ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Arthur Siebrecht M. D.

, 19 (Address) 330 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pen Bethlehem	Jul 13 1923
20 UNDERTAKER J. A. Moran	ADDRESS 3000 E Baltimore

IMPORTANT: PHYSICIANS should state with particularity. Exact statement of OCCUPATION may be properly classified. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Recurrent Carcinoma
of Rectum

Spec.—1-10-21—M&T—1500 Blks.

D77455

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77455

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Idiot Asylum ST. WARD)

2-FULL NAME John McLynn.

(a) RESIDENCE NO. 1825 Eastern Ave. ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Ireland

PARENTS

10 NAME OF FATHER John McLynn

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Munn

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Anna McLynn
(Address) 1325 E. Eastern Ave

15 Filed JUL 12 1923 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1923

17 I HEREBY CERTIFY, That I attended deceased from June 22 1923 to June 24 1923,
that I last saw h[illegible] alive on June 24 1923,
and that death occurred, on the date stated above, at [illegible].
The CAUSE OF DEATH* was as follows:

[illegible]

(duration) yrs. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Cathedral Cem	7/15 1923
20 UNDERTAKER J. G. Moran	ADDRESS 30a E Balto St.

IMPORTANT. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77456

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 ✓ D77456

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sallie Gintling,

(a) RESIDENCE NO. 1109 Callington Ave, ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. Gintling

6 DATE OF BIRTH (month, day, and year): Jan-4-1863

7 AGE: Years 60 | Months 6 | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: John Grottle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eliz Belchmus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant (Address): John Gintling Son. 1109 Collington

15 FILED JUL 12 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 11th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1923, to July 11th, 1923, that I last saw h[illegible] alive on July 11th, 1923, and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) — yrs. — mos 67 ds.

CONTRIBUTORY (Secondary) Varicose Ulcers (h) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harold C. Callaway, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 7/14 1923

20 UNDERTAKER: L. F. McAnally — ADDRESS: 130 E. Fort

...TION is very important. See instructions on back of certificates. ...that it may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

16 1363 D77457

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 135 D77457

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1 ST. (Norton) WARD)

2-FULL NAME Charles P Boston

(a) RESIDENCE NO. Buffalo ST. WARD N. Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
m	w	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 65				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer 042

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Buffalo (State or country) N. Y.

PARENTS

10 NAME OF FATHER Charles P Boston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn

12 MAIDEN NAME OF MOTHER Janette Phelps

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Baltimore

15 Filed JUL 12 1923 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1923

17

I HEREBY CERTIFY, That I attended deceased from June 12, 1923, to July 11, 1923, that I last saw him alive on July 11, 1923, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia secondary to peri urethral & periprostatic abscess —

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Peri urethral abscess

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 1st 23

Was there an autopsy? Yes

What test confirmed diagnosis? Blood culture

(Signed) Charles F. Bidgood, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Buffalo N Y	July 12 1923
20 UNDERTAKER H Jenkins & Son	ADDRESS 1520 Eutaw St

IMPORTANT: PHYSICIANS should state plainly and fully the CAUSE OF DEATH, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77458 D77458

CERTIFICATE OF DEATH.

REGISTERED No. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3709 Elliott ST.; No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Jones

(Residence in Baltimore: No. 3709 Elliott ST.; 64 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Aug (Month) 16 (Day), 1858 (Year)

7-AGE, 66 yrs. 10 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Night Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John Jones

11-BIRTHPLACE OF FATHER (State or Country), Wales.

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (State or Country), Wales

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Sarah Williams

(Address) 3719 Elliott

15-

Filed ..... 191.... ROBERT R. KRAUTER, Registrar.

JUL 12 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 12 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 20, 1923, to July, 191..., that I saw h-im alive on July 11th, 1923, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) (

(Duration) yrs. mos. ds.

(Signed) David A. Strauss M. D.

7/12, 1923 (Address) 1011 N. Ellwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mns. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem — DATE OF BURIAL, July 17, 1923

20-UNDERTAKER John Dillier — ADDRESS 2008 Aisquith

Property Condition. Exact statement of OCCUPATION is very important. Should state kind of work. Write plainly. Use black ink. Do not write on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D77459 HEALTH DEPARTMENT—CITY OF BALTIMORE. D77459

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 273 N Luzerne ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenneth Lee Wanner

(a) RESIDENCE NO. 273 N Luzerne ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 15 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Arthur H Wanner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Courtney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Arthur H Wanner

(Address) 273 N Luzerne Ave

15 Filed JUL 12 1923 19 ROBERT R. KRAUTER, Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1923

17 I HEREBY CERTIFY, That I attended deceased from July 3 — , 1923 , to July 11 , 1923 .

that I last saw him alive on July 11 , 1923 ,

and that death occurred, on the date stated above, at 5.20 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia Broncho

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Anemia Secondary to Malnutrition

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X ray & Blood Exam

(Signed) Chas Jos Gorlin , M. D.

, 19 (Address) 1011 N Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem

DATE OF BURIAL July 13 1923

20 UNDERTAKER John Ullrich

ADDRESS 200 E Lanvale

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

that it may be properly classified. PHYSICIANS should state

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, 6 *yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77460

CERTIFICATE OF DEATH.

74001 D77460

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5006 York Road ST., 27 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E Coleman

(a) RESIDENCE NO. 5006 York Road ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 22 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER W. T. D. Coleman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Penn

12 MAIDEN NAME OF MOTHER Elizabeth Amos

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Pennsylvania

14 Informant S E Coleman
(Address) 5006 York Rd

15 Filed JUL 12 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9 , 1923 , to July 11 , 1923 , that I last saw her alive on July 11 , 1923 , and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Cardiac Paralysis of
Myth Rebe

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. H. Duncan M. D.

July , 1923 (Address) 5006 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cem	July 13 1923
20 UNDERTAKER George E Smith	ADDRESS 1532 Pulaski

THION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec—12-23-21—E.B.R.S.—400 Blks.

D77461

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D77461

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1126 W. Baltimore St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Petzold

(a) Residence No. 1126 W. Baltimore St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) April 21, 1834

7-AGE. 89 yrs. mos. ds.

If LESS than 1 day, hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER Bernard Schreiber

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Barbara Dresler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Carrie Puppenaul

(Address) 167 N. Fulton Ave

15- JUL 12 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 12 1923

17- I HEREBY CERTIFY, That I attended deceased from July 1 1923 to July 11 1923

that I last saw h. alive on July 11 1923

and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 5 yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Coronary sclerosis

(Duration) 2 yrs. mos.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) 536 W. North Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park	July 14 1923
20-UNDERTAKER. George J. Smith	ADDRESS 153 Collins St

1-Enter exact statement of OCCUPATION is very important. See back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

77462

CERTIFICATE OF DEATH.

31 D77462

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.: 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Verlie Wright

(a) RESIDENCE. No. ..... ST., ... WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March-15-1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farm Hd

(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Fredrosville, Md.

PARENTS

10 NAME OF FATHER Stewart Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): C. D. Surrey Warden

15 Filed JUL 12 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July-7 1923

17 I HEREBY CERTIFY, That I attended deceased from January-30, 1923, to July-7, 1923, that I last saw him alive on July-7, 1923, and that death occurred, on the date stated above, at 9.10 P. m.

The CAUSE OF DEATH* was as follows:

Toxemia and Exhaustion

(duration) yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 6 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination.

(Signed) William R. Stewart, M. D.

7/8, 1923 (Address) Maryland Penitentiary.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	
20 UNDERTAKER	ADDRESS
Commissioner Health.	

MORGUE

TION is very important. See instructions on back of certificates.

...ease in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

...stated EXACTLY. PHYSICIANS should state

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D77463

D77463

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 Eastman ST., 15 WARD)

2-FULL NAME Walter Wells

(a) RESIDENCE NO. 1505 Eastman ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) about 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Produce Packer
(b) General nature of industry, business, or establishment in which employed (or employer) Fruit restaurant
(c) Name of employer T. H. Evans, Co

9 BIRTHPLACE (city or town) Kentucky
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14
Informant Emma Jackson
(Address) 1505 Eastman St

15
Filed JUL 12 1923, 192 ROBERT R. KRAUTER Registrar
Burial Permit Ck'd.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 192 3

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 9 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. C. Hemmeter, M. D.
(Coroner.)
June 11, 192 3 (Address) 1 Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL 192

20 UNDERTAKER

ADDRESS

JUL 12 1923

Commissioner Health.

Exact statement of OCCUPA-
Instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D77464

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 D77464

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 4 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mary Archibald

(a) Residence No. 10 E. Mulberry St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): 1868

7-AGE: 54 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Scotland

PARENTS.

10-NAME OF FATHER: John Archibald

11-BIRTHPLACE OF FATHER (city or town) (State or Country): England

12-MAIDEN NAME OF MOTHER: Isabella Bodsmith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): England

11- (Informant) Municipal Hospital Records

(Address)

15- FILED JUL 12 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 11, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 21 19 23 to July 11 19 23.

that I last saw her alive on July 11 19 23.

and that death occurred, on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (Terminal) (Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N. Goodsmith M. D.

7-13 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: July 12 1923

20-UNDERTAKER: Mrs Maude Funk — ADDRESS: 1737 E Fayette St

Fold on back of certificates. Each statement of OCCUPATION is very important. See

Spec.—1-10-21—M&T—1500 Blks.

D77465

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D77465

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hosp. ST. 20 WARD)

2-FULL NAME Louis Roos.

(a) RESIDENCE NO. 2634 Maimples Lane. ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 8 mos. 29 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Bertha Roos

6 DATE OF BIRTH (month, day, and year) Sept 14-1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 043

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer John Hepner Balto.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Leopard Roos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Victoria Gobelle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lewis Roos
(Address) 2634 Maimples

15 JUL 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1923

17 I HEREBY CERTIFY, That I attended deceased from July 11 1923 to July 12 1923.

that I last saw him alive on July 12 1923

and that death occurred, on the date stated above, at 12 35 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward A. Krukowski, M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pine Lawn Park	July-14 19 23

20 UNDERTAKER	ADDRESS
F.B. Keppert	223 Fulton Ave

TION is very important. See Instructions on back of certificates. Exact statement of OCCUPA-

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77466

CERTIFICATE OF DEATH.

1329 D77466

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 739 W.Cross st. ST.; 21 WARD) REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Simon Pfeffer

(Residence in Baltimore: No. 739 W.Cross st. St.; 55 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, May 22/1841. (Month) (Day), 1 (Year)

7-AGE, 82 yrs. 1 mos. 17 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Cabinet-Maker

9-BIRTHPLACE, (State or Country), Germany 014

PARENTS.

10-NAME OF FATHER, John Pfeffer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catharine Hockler

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lena Waldschmidt (Daughter)

(Address) No.618 W.Hamburg st.

15- JUL 12 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 10/1923., 191 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 7/23. 191, to July 10/23. 191, that I saw h im alive on July 10/23. 191, and that death occurred, on the date stated above, at 12, noon

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis.

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos.

(Signed) Henry Waldschmidt M. D.

July 11/26 (Address) 933 Hanover st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park Cemetery

DATE OF BURIAL. 7/13, 1923

20-UNDERTAKER Geo Leimbach & Son

ADDRESS 647 W Pratt St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77467 — 1-PLACE OF DEATH

D77467 — REGISTERED NO.

CITY OF BALTIMORE, (No. St Agnes Hospital ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Mills.

(a) RESIDENCE NO. 211 N. Blount St. Raleigh, N.C. WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 7 weeks ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julian E. Johnson

6 DATE OF BIRTH (month, day, and year): Jan. 9, 1858

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
65 yrs	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country): " "

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant: H. H. Mills

(Address): 418 So Bayboro Ave Raleigh N.C.

15 Filed JUL 12 1923 ROBERT R. KRAUTER, Registrar

Via Penn. Railroad—Edmonds, Ward & Co. Mills

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1923

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1923, to July 12, 1923, that I last saw him alive on July 12, 1923, and that death occurred, on the date stated above, at 10 50 m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis—

Myocarditis. (arterio-sclerotic)

(duration) 2 yrs.? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward A. Kotowski, M. D.

, 19 St Agnes Hospital, (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakwood Cemetery, Ral., N.C.	7/13, 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	905 N. Calvert

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- at it may be properly classified. PHYSICIANS should state

S·A·F·E·T·Y

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77468

CERTIFICATE OF DEATH.

X 44

D77468

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Bolton ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hiram Wilson.

(a) RESIDENCE. NO. 1424 Bolton ST., WARD. Ohio

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lydia Beetman Wilson

6 DATE OF BIRTH (month, day, and year) Aug. 22nd 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
42.		10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Concord Ohio

PARENTS

10 NAME OF FATHER Henry Wilson.

11 BIRTHPLACE OF FATHER (city or town) Concord (State or country) Ohio.

12 MAIDEN NAME OF MOTHER Elizabeth A. Weaver

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Ohio.

14 Informant Mrs. L. B. Wilson

(Address) 1424 Bolton St.

15 JUL 12 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 15 1923 to July 12 1923 that I last saw h[illegible] alive on July 11. 1923 and that death occurred, on the date stated above, at 8.20 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) William Michel M. D.

1923 (Address) 2401 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state: (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL.

Paines ville, Ohio July 13th 1923

20 UNDERTAKER. ADDRESS

Joseph B Cook 1013 N Bulton

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D77469 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 D77469

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 512 N. Decker ave. ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Willey

(Residence in Baltimore: No. 512 N. Decker ave St.; Life yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, December 15th, 1890. (Month) (Day) (Year)

7-AGE, 32 yrs. 6 mos. 24 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Frederick W. Bellman

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Mary E. Harrington

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur Willey

(Address) 512 N. Decker ave

15- Filed JUL 13 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 10th, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 15th 1923, to July 10th 1923, that I saw her alive on July 9th 1923, and that death occurred, on the date stated above, at 10.20 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. 25 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) David W. Jones M. D.

7/10/, 1923 (Address) 1011 N. Ellwood ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery — DATE OF BURIAL, July 13, 1923

20-UNDERTAKER H. Wander & Sons — ADDRESS 710 Flat St.

Please see instructions on back of certificate. Exact statement of OCCUPATION is very important and should state properly classified.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D77470

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77470

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Sisters of the St. Francis 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Gray

(a) Residence No. 1 Preston & Valley Sts. Ward

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, ~~Married~~ Widowed or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 92 yrs. — mos. — ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), State of Virginia

PARENTS.

10-NAME OF FATHER, Peter Gray

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Margaret Hesler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

11- (Informant) Sister Florence

(Address) Preston & Valley Sts

15- Filed JUL 13 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 12 1923

17- I HEREBY CERTIFY, That I attended deceased from to record 19 to 19

that I last saw h[illegible] alive on July 8 1923

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Arteria sclerosis

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

July 12, 1923 (Signed) F. A. Warner, M. D (Address) 1123 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cemetery Elkridge Md. DATE OF BURIAL. July 13, 1923

20-UNDERTAKER, Henry Storck Son 1301 E Eager St ADDRESS

Instructions on back of certificates.

IMPORTANT. Exact statement of OCCUPATION is very important. See

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77471

D77471

CERTIFICATE OF DEATH.

1792

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Colette Madden

(Residence in Baltimore: No. 1124 Barclay St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Single

6-DATE OF BIRTH: Feb (Month) 21 (Day) 1916 (Year)

7-AGE: 7 yrs. 4 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none

9-BIRTHPLACE (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Thos. Madden

11-BIRTHPLACE OF FATHER (State or Country): Balto

12-MAIDEN NAME OF MOTHER: Rose McKenna

13-BIRTHPLACE OF MOTHER (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Madden

(Address) 1124 Barclay

15-

Filed JUL 13 1923 [illegible] Registrar.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH: July (Month) 12th (Day) 1923 (Year)

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an McGinn (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said McGinn (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gen. burns. due to
Match. accidental
Fatal (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)
July 12 1923 (Address) 1057 Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death Sunday yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: New Cathedral Cemetery DATE OF BURIAL: July 14 1923

20-UNDERTAKER: Henry Houck & Son ADDRESS: 1301 E. Eager St.

Do not write in this space. PHYSICIANS should be very important. See instructions on back of certificate. It may be properly classified. Exact statement of OCCUPATION

Spec.—3-10-21—M&T—1500 Bks.

D77472

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77472

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen'l. Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CALVERT BURKE GILL

(a) RESIDENCE NO. 1406-Linden-Av. ST., 14 WARD (Resident)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 5 mos. 8 ds. How long in U. S., If of foreign birth? 40 yrs. 5 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anne Streett

6 DATE OF BIRTH (month, day, and year): Feby-3-1883

7 AGE — Years: 40 — Months: 5 — Days: 8 — If LESS than 1 day, hrs or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lawyer

(b) General nature of Industry, business, or establishment in which employed (or employer): Law

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: N. Rufus Gill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER: E. Agnus Gill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant: Mr. C. Herbert Rice, (Bro-in-law)
(Address) Catonsville, Md.

15 JUL 13 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 11 1923

17 I HEREBY CERTIFY, That I attended deceased from July 5 1923 to July 11 1923 that I last saw him alive on July 11 1923 and that death occurred, on the date stated above, at 5:55 P m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis
(Gangrenous)

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary): Toxemia from acute peritonitis (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 7-5-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Jno A Thompkins, M. D.

, 19 (Address) U Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: GREENMOUNT CEMETERY

DATE OF BURIAL: July-14-23

20 UNDERTAKER: [illegible] & MOWEN COMPANY
(WILLIAM F. MOWEN)

ADDRESS: 108 W. NORTH AVE

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- at it may be properly classified. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Blks.

D77473 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

114 D77473

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 Moreland Ave ST. 15 WARD)

2-FULL NAME Ida Bell White

(a) RESIDENCE NO. 1723 Moreland Ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 11 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Milton White

6 DATE OF BIRTH (month, day, and year) July 20 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 037

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Wm C. Blackstone

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Tomlinson

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mr. Milton White (Address) 1723 Moreland Ave

15 Filed JUL 13 1923 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1923

17 I HEREBY CERTIFY, That I attended deceased from July 11 1923 to July 12 1923.

That I last saw her alive on July 12 1923

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute gastro-enteritis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Homer C. Todd M. D.

7/13 1923 (Address) 735 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	July 14 1923
20 UNDERTAKER Wm Tickner & Sons	ADDRESS North Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA- at it may be properly classified. PHYSICIANS should state plain terms, so that it m

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77474

CERTIFICATE OF DEATH.

40 D77474

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 Hanover St. ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Quill. (C).

(a) RESIDENCE NO. 813 Hanover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Deckhand, 074
(b) General nature of industry, business, or establishment in which employed (or employer) Tolchester S/S Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co Md.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Florence Wilson. (C). (Address) 813 Hanover St.

15 JUL 13 1923 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart & kidneys.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Chas. C. Reinhardt M. D.

(Address) 1014 E. Charles St. July 12, 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL July 13 1923

20 UNDERTAKER R L Parham

ADDRESS 902 Eadenhall

(2) Exact statement of OCCUPATION should be given. Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(3) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(4) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(5) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(6) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(7) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(8) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(9) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(10) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(11) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(12) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(13) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

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(15) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

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(100) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(101) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(102) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(103) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(104) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(105) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(106) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(107) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(108) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(109) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(110) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(111) Write plainly with pen and ink. Use no abbreviations. Do not report "laborer," "housewife," "clerk," "factory," "retired," or "none." Do not report occupation that was merely incidental or transitory. Report the occupation followed for the longest period of life. Do not report nationality instead of occupation. Do not report cause of death in this item. Do not report "yes" or "no" in any item.

(112) Write plainly with pen and ink. Use

Spec.—1-10-21—M&T—1500 Bks.

Dr Frank Clyde Clarke. 49

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77475 — REGISTERED NO. D77475

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3504 Fleet St. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Uhl.

(a) RESIDENCE NO. 3504 Fleet St. ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Uhl.

6 DATE OF BIRTH (month, day, and year) May 15—1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57.	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer L. Pellmayer & Sons.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Adam Uhl.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Julia Uhl. (Address) 3504 Fleet St.

15 JUL 13 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1920, to July 11— 1923.

that I last saw him alive on July 10 1923,

and that death occurred, on the date stated above, at 6. oo A. m.

The CAUSE OF DEATH* was as follows:

Cancer of Lung

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) A Hertzler M. D.

, 19 (Address) 340 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL July 14 1923.

20 UNDERTAKER Tilly & Zuiler ADDRESS 403 S Broadway

IMPORTANT: PHYSICIANS should state plainly all terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77476 D77476

CERTIFICATE OF DEATH.

1329

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3415 Foster Ave. ST., No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Willebald H. Lightner

(a) RESIDENCE No. 3415 Foster Ave ST., 76 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Lightner

6 DATE OF BIRTH (month, day, and year): June 1 — 1847

7 AGE: Years 76 Months 1 Days 11 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Anton Lightner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Walburga Benziger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Elizabeth Lightner

(Address) 3415 Foster Ave.

15 Filed JUL 13 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 14 1923.

17 I HEREBY CERTIFY, That I attended deceased from ... 19 ... to July 12 1923.

that I last saw him alive on July 11 1923,

and that death occurred, on the date stated above, at 8.00 A. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis — Uremia — Coma. — One year & half.

(duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary) Mitral Insufficiency.

(duration) 1½ yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Evaluation

(Signed) ... M. D.

1923 (Address) 3568 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: July 14 1923.

20 UNDERTAKER: Lilly and Zeiler. ADDRESS

TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D77477 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

177-001 D77477

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Nursery Hospital (ST.) 21 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant Baggot

(a) RESIDENCE NO. 1547 Burgundy (ST.) (WARD)

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	11			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER John W Baggot

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Hazel Burns

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Hospital Records
(Address)

15 JUL 13 1923 [illegible] Registrar
Filed , 192

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an [redacted] autopsy or inquiry.) thereon and from the evidence obtained by said [redacted] au-topsy or inquiry.) find that said deceased came to [redacted] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurus Birth from Pyelonephritis Acute & Chronic Cystitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Accident or Delay

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Physician or Coroner.)

7-12, 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 14 1923
20 UNDERTAKER	ADDRESS
Lowe Cook	502 E Monument

Instructions on back of certificate. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

D77478 HEALTH DEPARTMENT—CITY OF BALTIMORE 8 D77478

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 10 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Thomas Hopkins.

(a) RESIDENCE NO. 712 N. Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
mall	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 14 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. md

PARENTS

10 NAME OF FATHER Michael T. Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. md.

12 MAIDEN NAME OF MOTHER Helen Wolfe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. md.

14 Informant Michael J. Hopkins

(Address) 712 N Gay St

JUL 13 1923 J. L. K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1923

17

I HEREBY CERTIFY, That I attended deceased from July 11, 1923, to July 12, 1923, that I last saw him alive on July 12, 1923, and that death occurred, on the date stated above, at 12:45 P m.

The CAUSE OF DEATH* was as follows:

Scarlet fever.

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) B Macgregor, M. D.

(Address) Sydenham Hosp. 7/13/23

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross cemetery	7/13 1923
20 UNDERTAKER H. E. Cook	ADDRESS 504 E Hoffman

IMPORTANT. PHYSICIANS should state plainly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Ida. Lordon)

D77479 HEALTH DEPARTMENT—CITY OF BALTIMORE 39 D77479

Duplicate

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Fordon

(a) RESIDENCE NO. 1017 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred about 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Lordon

6 DATE OF BIRTH (month, day, and year): Nov 7-1890

7 AGE: Years 32 Months 8 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Geo. W. Himes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary E. Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mo

14 Informant: James Lordon

(Address) 1019 N. Charles St.

15 Filed JUL 13 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-12-1923

17 I HEREBY CERTIFY, That I attended deceased from 7-3-, 19 23, to 7-12-, 19 23,

that I last saw her alive on 7-12-, 19 23,

and that death occurred, on the date stated above, at 5:30 a.m.

The CAUSE OF DEATH* was as follows:

Multiple fibroids of uterus

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Complete Ileus

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7-1-23

Was there an autopsy? no

What test confirmed diagnosis? Op. & Path. findings

(Signed) Newton J. Carr, M. D.

7-13-1923 (Address) Franklin Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore City

DATE OF BURIAL: 16 1923

20 UNDERTAKER: H. C. Windefeld

ADDRESS: 914 Greenmount Ave

TION is very important. See instructions on back

may be properly classified. Exact statement of OCCUPA-

PHYSICIANS should state

be filled EXACTLY.

Spec.—1-10-21—M&T—1500 Blks.

D77480

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77480

CERTIFICATE OF DEATH.

1329

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 801 E 22 nd St., 9 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tom Grady

(a) RESIDENCE NO. 801 E 22 nd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 51 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary A Grady

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 82 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary A Grady (Address) 801 E 22nd St

15 Filed OCT 13 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 15 1923 to July 12 1923 that I last saw h[illegible] alive on July 12 1923 and that death occurred, on the date stated above, at 7.15 a m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) 5 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Stanley Goodall M. D.

, 19 (Address) 1900 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: July 14 1923

20 UNDERTAKER: Pott & Turner Co — ADDRESS 1442 W Broadway

IMPORTANT: PHYSICIANS should state at it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D77481

D77481

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 101 So. Highland ave WARD 16 90)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Robinson

(a) RESIDENCE NO 101 S. Highland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ (or) WIFE of Oliver W. Robinson

6 DATE OF BIRTH (month, day, and year) July 12 1860

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62	11	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Oliver W. Robinson
(Address) 101 So. Highland ave

15 Filed JUL 13 1923 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation
Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Thos. B. Horton, M. D.
(Coroner.)

July 13th, 1923 (Address) Curtis Bay, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL July 14 1923

UNDERTAKER John Ellis & ADDRESS 29 Elam

Cor.—1-12-23—M&T—100 Bks. Place statement of OCCUPA- ... back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77482

CERTIFICATE OF DEATH

D77482

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 North Curley ST., 6 WARD)

2-FULL NAME Micheal Young

(a) RESIDENCE NO. 1 N. Curley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of (or) ~~WIFE of~~ Sophie Young

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	6.	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Micheal Young

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Sophie Young
(Address) 1 N. Curley St. J.

15 Filed JUL 13 1923 17 ROBERT R. KRANTZ, Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 19 23

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10. 19 16. to July 11. 19 23.

that I last saw h alive on July 11. 19 23.

and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John G. Ourso, M. D.

19 (Address) 35 W Pleasant St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem — DATE OF BURIAL July 14 1923

UNDERTAKER John Sellers — ADDRESS 27 E Lanvale

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77483

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

135 D77483

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Fawcett & Green ST. S 9 WARD)

2-FULL NAME John Jennis Dobler

(a) RESIDENCE NO. 2224 Mayfield Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male | 4 COLOR OR RACE white | 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Emma Dobler

6 DATE OF BIRTH (month, day, and year) June 6. 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Judge

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Dobler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Seebold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Geo. Dobler

(Address) 1902 Kennedy ave

15 Filed JUL 13 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-12 1923

17 I HEREBY CERTIFY, That I attended deceased from 7-7, 1923 to 7-12, 1923

that I last saw him alive on 7-12, 1923

and that death occurred, on the date stated above, at 10:26 p.m.

The CAUSE OF DEATH* was as follows:

(1) myocardial insufficiency

(2) Hypostatic pulmonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic bronchitis (duration) yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7-8-1923

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) R. H. Slayton M.D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL 7/14 1923

20 UNDERTAKER Chas F. Evans & Son

ADDRESS 1180 W. Mt. Royal Ave

THIS IS very important. See instructions on back of certificates. PHYSICIANS should state may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

D77484 HEALTH DEPARTMENT—CITY OF BALTIMORE 32 D77484

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francisco Maldonado.

(a) RESIDENCE No. St Marys Ind. School ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: N.

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ~~Single~~

6 DATE OF BIRTH (month, day, and year) Unknown 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Porto Rico

PARENTS

10 NAME OF FATHER: Francisco Maldonado

11 BIRTHPLACE OF FATHER (city or town) (State or country): Do not know

12 MAIDEN NAME OF MOTHER: Do Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Do not know

14 Informant: Francisco Maldonado

(Address): St Marys Ind Sch

15 JUL 13 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1923

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1923, to July 12, 1923.

That I last saw h[illegible] alive on July 12, 1923,

and that death occurred, on the date stated above, at 10 20 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Exhaustion yrs. mos. ds.

18 Where was disease contracted if not at place of death? St. Marys Ind. School.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy

(Signed) L. Clement Cohn M. D.

, 19 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bethel Cemetery

DATE OF BURIAL: 7/14 19 23

20 UNDERTAKER: Chas. P. Evans & Son

ADDRESS: 1800 N. Royal Ave

IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77485

CERTIFICATE OF DEATH.

57 ✓ D77485

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2836 Guilford Ave. ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma F. Bayne

(a) RESIDENCE NO. 2836 Guilford Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A. Bayne

6 DATE OF BIRTH (month, day, and year) June, 1st., 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas Bowling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susana Boome

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Bessie Ellerbrock

(Address) 2836 Guilford Ave.

15 JUL 13 1923 ROBERT R. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10-July 1923

17 I HEREBY CERTIFY, That I attended deceased from 10-June, 1920, to 10-July, 1923

that I last saw her alive on 10-July, 1923

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Diabetes (Mellitus)

(duration) 20 yrs. ✓ mos ✓ ds.

CONTRIBUTORY (Secondary) Acidity + Coma

(duration) 10 yrs 2 mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinary

(Signed) H. Stanley Grasnick, M. D.

12 June 1923 (Address) 1900 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	7/14/23
20 UNDERTAKER	ADDRESS
Chas. F. Evans & Son	118 W. Mt. Royal Ave.

TION is very important. See instructions on back of certificates.

...t it may be properly classified. Exact statement of OCCUPA-

...PLAIN terms, so that it may ... PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77486

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 3 D77486

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1705 Byrd ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry J. Fetkays

(a) RESIDENCE. NO. 1705 E Byrd ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residance in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 27, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Michael Fetkays

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Jennie Lehr

13 BIRTHPLACE OF MOTHER (city or town) N. Y. (State or country)

14 Informant Mrs. Jennie Fetkays (Address) 1715 Byrd St.

15 Filed JUL 13 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/12/1923

17

I HEREBY CERTIFY, That I attended deceased from July 6, 1923, to July 12, 1923, that I last saw h~~im~~ alive on July 12, 1923, and that death occurred, on the date stated above, at 6.20 A m.

The CAUSE OF DEATH* was as follows:

acute Gastro Enteritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R. L. Campbell M. D.

July 13, 1923 (Address) 1044 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	7/14 '23

20 UNDERTAKER J. D. Young ADDRESS 1460 Baltimore

FOR IS very important. See instructions on back of certificates. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77487

CERTIFICATE OF DEATH.

90 ✓ D77487

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 314 E. University Parkway ST., 12 WARD)

2-FULL NAME John Lee Mueller

(a) RESIDENCE No. 314 E. University Parkway ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary C. Mueller

6 DATE OF BIRTH (month, day, and year) — — 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Builder

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Matthew Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lee Mueller
(Address) 314 E. University Pky

15 Filed JUL 13 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11, 1923

17 I HEREBY CERTIFY, That I attended deceased from September, 1922 to July 11, 1923.

that I last saw him alive on July 11, 1923.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Acute Hepatitis

(duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Appearance

(Signed) Benj. D. Hayden M. D.

7/13/1923 (Address) 1216 N. Caroline at

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loby Cemetery	7/14 1923
20 UNDERTAKER J. Fahey Sons	ADDRESS 1918 Eastern

TION is very important. See instructions on back of certificates. PHYSICIANS should state may be properly classified. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

D77488

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D77488

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 Edondale Ave ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E Rider

(a) RESIDENCE NO. 8 Edondale Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a ~~If married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Edw Rider Jr

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thos Ball

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs E Rider

(Address) 8 Edondale Ave

15 Filed JUL 13 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept, 1922, to July 11, 1923,

that I last saw her alive on July 9, 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma vulvae

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) uremia

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of about Sept. 1922

Was there an autopsy? no

What test confirmed diagnosis? microscopic

(Signed) Edward Rosa, M. D.

, 19 (Address) Patterson Pk & N. Point Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 7/14 1923

20 UNDERTAKER J. Wesley Wood

ADDRESS 131 N. Eutaw St

IMPORTANT. See instructions on back of certificates.

D77489

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11 100-001

D77489

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 890. TYSON ST. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... WILLIAM T. WYATT.

(Residence in Baltimore: No. 890. TYSON ST. St.; yrs. 1 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write)
MALE.	COLORD.	SINGLE.

6-DATE OF BIRTH. AUG. 8. 1922. (Month) (Day) (Year)

7-AGE. ..... yrs. 11 mos. 4 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... NO.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). BALTIMORE CITY.

PARENTS.

10-NAME OF FATHER. HARVEY WYATT

11-BIRTHPLACE OF FATHER, (State or Country). VA.

12-MAIDEN NAME OF MOTHER. MARY BARNES.

13-BIRTHPLACE OF MOTHER, (State or Country). MD.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) HARVEY WYATT.

(Address) 890. TYSON ST.

15- JUL 13 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 12 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

1. Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

July 13 1923 (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	July 15 1923
20-UNDERTAKER.	ADDRESS
David Eastern	Penna Ave

Very important. See instructions on back of certificate. It may be properly classified. Exact statement of OCCUPATION may be

Spec.—1-10-21—M&T—1500 Rls.

164884 8 lo A.M. D77490

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓-001

CERTIFICATE OF DEATH.

161 D77490

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 1 WARD)

2-FULL NAME Christine Harney.

(a) RESIDENCE NO. 216 S. Robinson St. ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. unknown mos. ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 25, 1923.

7 AGE — Years: ..... Months: 2 weeks Days: 2

If LESS than 1 day,... hrs. or..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Lewis E. Harney.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Catherine Camella

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: JOHNS HOPKINS HOSPITAL (Address)

15 Filed JUL 13 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 11th, 19.. to July 11, 1923.

that I last saw her alive on July 11, 1923,

and that death occurred, on the date stated above, at 8 40 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) Life mos ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? X Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. R. Mixsell, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: 7/13 1923

20 UNDERTAKER: J. J. Moran — ADDRESS 3 and E Baltimore

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77491

CERTIFICATE OF DEATH.

44 D77491

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2708 Chelsea Ter St.: 19 Ward)

2-FULL NAME Lena A. Korb

(a) RESIDENCE. No. 2706 Parkwood Ave St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 3 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward M. Korb

6 DATE OF BIRTH (month, day, and year) May 5 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pittsburgh Pa.

PARENTS

10 NAME OF FATHER Charles Friese

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Brunner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Edward M. Korb
(Address) 2706 Parkwood Ave

15 Filed JUL 13 1923 19 ROBERT R. KRANTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1923 to July 13, 1923 that I last saw h[illegible] alive on July 13, 1923 and that death occurred, on the date stated above, at 12.30A m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Stomach

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of Apr 23 1923

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic

(Signed) Nathaniel Gatch, M. D.

19 (Address) 2731 Parkwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	July 16 1923
20 UNDERTAKER	ADDRESS 1039
E. Ackleman & Son	Fremont Ave

IT IS very important. See instructions on back of certificates. Exact statement of OCCUPATION may be properly classified. PHYSICIANS should state cause of death so that it may be understood by the laity. Full statement of information CAREFULLY.

Spec.—1-10-21—M&T—1500 Bks.

Burden.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D 77492

D 77492

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen Hospital St. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jack Burden

(a) RESIDENCE NO. 3824 Kate Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11, 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Detroit.
(State or country) Mich.

PARENTS

10 NAME OF FATHER Conrad E. Burden

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER ----Groth

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Conrad E. Burden,
(Address) 3824 Kate Ave.,

15 FILED JUL 13 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-12-23

17 I HEREBY CERTIFY, That I attended deceased from 7-11-23, to 7-12-23.

that I last saw him alive on 7-12-23,

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Fract. Femur. tx.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Embolism. Acute

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? City

Did an operation precede death? Yes Date of 7-11-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) John A. Young M. D.

, 19 (Address) Md Gen Hospx.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 7/14 19 23

20 UNDERTAKER Harry H. Witzke

ADDRESS 1531 W. Lombard

THIS is very important. See instructions on back of certificates. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION so that it may be properly classified. Exact statement of OCCUPATION so that it may be properly classified. Exact statement of OCCUPATION so that

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter. Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accident
3 mts ago Tripped on
a "Scooter" while play
Ind. 4 hours 3 days
ago, repeated same
thing fracturing same
femur as above 2
months prior.

Spec.—1-10-21—M&T—1500 Blks.

D77493 HEALTH DEPARTMENT—CITY OF BALTIMORE 141 ✓ D77493

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Genl. Hospt. ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sarah Estelle Marsh.

(a) RESIDENCE NO. 5250 Reisterstown Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married.

5a If married, widowed, or divorced (~~Husband of~~ or) WIFE of John Tolly Marsh.

6 DATE OF BIRTH (month, day, and year) May 22" 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford County.

PARENTS

10 NAME OF FATHER James Watt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford County.

12 MAIDEN NAME OF MOTHER Eleanora Merryman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford County.

14 Informant Rev. J. Tolly Marsh

(Address) 5250 Reisterstown Rd.

15 JUL 13 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1923

17 I HEREBY CERTIFY, That I attended deceased from July 5 1923. to July 13 1923. that I last saw her alive on July 13 1923, and that death occurred, on the date stated above, at 1:55 P.m.

The CAUSE OF DEATH* was as follows:

Operation — Perineorraphy & Suspension of Uterus. for Prolapse of Uterus & Elongatem of Cervix (duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary) Genl. Sepsis & Cerebral Embolism (?) Secondary Paroditis, (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 7/6/23.

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) George E. Spangler, M. D.

7/13, 1923 (Address) Maryland Genl. Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Druid Ridge Cem	July 16 1923
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 N. Bolton St

THION is very important. See instructions on back of certificates. that it may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77494 — 129 — D77494

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3700 Chatham Rd ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Cecelia Richardson

(a) RESIDENCE. NO. 3700 Chatham Rd ST., WARD.

(Usual place of abode) about 40

(If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? — yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of E. R. Richardson

6 DATE OF BIRTH (month, day, and year) Nov 10 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER Hugh Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Ellen Kidd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cecil Co Md

14 Informant Elmer E Richardson

(Address) 3700 Chatham Rd

15 JUL 13 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 - 1922, to July 13 - 1923, that I last saw h e alive on on July 12 - 1923, and that death occurred, on the date stated above, at 5.15 a. m.

The CAUSE OF DEATH* was as follows: Cerebral Arterio Sclerosis

about 18 months

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Enuresis

3 or 4 months

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Necropsy

(Signed) Carlton A Pratt M. D.

July 16, 1923 (Address) 2219 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	July 16 1923
20 UNDERTAKER	ADDRESS
John O. Mitchell	201 W Fayette

IMPORTANT. PHYSICIANS should state terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77495 HEALTH DEPARTMENT—CITY OF BALTIMORE D77495

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 1128 St Paul St., Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Norris

(Residence in Baltimore: No. 112 Center E St.; 10 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Mal	Col.	Married

6-DATE OF BIRTH: Feby 14 1883 (Month) (Day) (Year)

7-AGE: 39 yrs. 11 mos. 3 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Painter
(b) General nature of Industry, business, or establishment in which employed (or employer): Self

9-BIRTHPLACE (State or Country): Md

PARENTS.

10-NAME OF FATHER: H Norris

11-BIRTHPLACE OF FATHER (State or Country): Md

12-MAIDEN NAME OF MOTHER: Em. Palmer

13-BIRTHPLACE OF MOTHER (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Norris

(Address) 112 E. Center

15- Filed JUL 13 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH: July 11 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. of skull accident
Fell from roof to pavement
(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.
(Coroner)
July 13 1923 (Address) 1129 Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
New Cathedral	7, 14, 23.
20-UNDERTAKER.	ADDRESS
Jos A Gilson	513 Lanvale St

Is very important. See instructions on back of certificate. ... may be properly classified. Exact statement of OCCUPATION ... ACCURATELY. PHYSICIANS should ...

Spec.—1-10-21—M&T—1500 Bks.

163818
D77496

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 06 P.M.

1-001

D77496

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Buckner.

(a) RESIDENCE No. 2314 Druid Hill Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. unknown mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Percy Buckner.

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE — Years: 21. Months: ..... Days: ..... If LESS than 1 day, hrs. ..... or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): JOHNS HOPKINS HOSPITAL.

15 Filed JUL 14 1923 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1923

17

I HEREBY CERTIFY, That I attended deceased from May 21, 1923. to July 12, 1923.

that I last saw her alive on July 12, 1923.

and that death occurred, on the date stated above, at 5 06 p. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) yrs. 2 mos 15 ds.

CONTRIBUTORY (Secondary): Pyonephrosis

(duration) yrs. ..... mos. 25 ds.

18 Where was disease contracted if not at place of death? Not determined.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Chas R Bugg, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: July 16 1923

20 UNDERTAKER: John H. Toadvine — ADDRESS 1732 Ursul St

TION is very important. See instructions on back of certificates. It may be properly classified. Exact statement of OCCUPA- terms, so that it may be stated EXACTLY. PHYSICIANS should state ...ment of infor-

important. See instructions on back of certificate.

D77497

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77497

1-PLACE OF DEATH (on the Street Enmd) REGISTERED No. C

CITY OF BALTIMORE (No. W. North Ave & Dukeland St.; WARD)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Bundy

(Residence in Baltimore: No. 147 N. Montgomery St.; yrs., 20 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	colored	married

6-DATE OF BIRTH, ... July 8, 1874
(Month) (Day) (Year)

7-AGE, 49 yrs. 5 mos. 4 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... (Canal)

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Silis Bundy

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Mrs. Sarah Scarbo

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mamie Garrett

(Address) 147 N. Montgomery

15- Filed JUL 14 1923, 19.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July 12, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) no Contributory

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

July 13, 1923 (Address) 222 Edmondson

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Zion Ct	July 12, 1923
20-UNDERTAKER	ADDRESS
E. A. Brown & Son	1014 Madison

Spec.—1-10-21—M&T—1500 Blks.

D77498

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77498

1-PLACE OF DEATH (Mrs Florence Holloway)

CITY OF BALTIMORE: (No.) Union Memorial Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Harry H. Holloway (Florence)

(a) RESIDENCE NO. Aberdeen ST. Maryland WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Holloway

6 DATE OF BIRTH (month, day, and year) Sept 25, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	59	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Collum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Harry Holloway (Address) Aberdeen Md.

15 Filed JUL 14 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1923

17

I HEREBY CERTIFY, That I attended deceased from January 15, 1923, to July 14, 1923, that I last saw her alive on July 14, 1923, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of vertebra with metastasis.

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Jan 23, 1923

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) John F Finney M. D.

, 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Aberdeen Cem DATE OF BURIAL 7/14 1923

20 UNDERTAKER Wm J Tuckwell & Son ADDRESS North & Pa aves

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77499

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-00 D77499

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No. Provident Hospital ST., 11 WARD)

2-FULL NAME James Fowlkes

(a) RESIDENCE NO. 861 North Side, Sparrows Point, Md ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Betty Fowlkes.

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) Labor 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Richard Fowlkes.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Susan Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Betty Fowlkes

(Address) 1732 Ashland Ave

15 Filed JUL 14 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-12 1923

17

I HEREBY CERTIFY, That I attended deceased from 7-2, 1923, to 7-12, 1923.

that I last saw him alive on 7-11 1923

and that death occurred, on the date stated above, at 12.45 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) Geo. C. Page M. D.

, 19 (Address) 1720 n. mount st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Crem. State not	July 14th
20 UNDERTAKER	ADDRESS
Mrs Robert F Elliott	Woodland Ave

TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77500

CERTIFICATE OF DEATH.

90 D77500

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 546 W. Preston St.: 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Scott

(a) RESIDENCE. No. 546 W. Preston St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos H Scott

6 DATE OF BIRTH (month, day, and year): 1847

7 AGE: Years 76; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Centerville Md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Conner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Centerville Md

14 Informant: Albert J. Brown
(Address): 944 Druid Hill

15 Filed JUL 14 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1923

17 I HEREBY CERTIFY, That I attended deceased from March 3 1923, to July 12 1923.
That I last saw h alive on July 11 1923,
and that death occurred, on the date stated above, at 4 P. m.
The CAUSE OF DEATH* was as follows:

Senility
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Organic Disease Heart
(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jas L Hooper, M. D.

7/17 1923 (Address) 346 E. 25th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ~~Pat Cemetery~~ National

DATE OF BURIAL: July 15 1923

20 UNDERTAKER: Mrs Poteet & Elliott

ADDRESS: 1725 Oakland

ITEM of information is very important. See instructions on back of certificates. PHYSICIANS should state EXACTLY. Exact statement of OCCUPATION may be properly classified. Exact statement of OCCUPA-

D77501

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77501

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Died en-route to

City of BALTIMORE: (No. St. Joseph Hospital St. 8 Ward)

Registered No. C 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Moore

(Residence in Baltimore: No. 2046 Keyser St. St.; 16 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	colored	married

6-DATE OF BIRTH. Feb 9/1878 (Month) (Day) 1 (Year)

7-AGE.	If LESS than 1 day.
45 yrs. 5 mos. 2 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teamster
(b) General nature of industry, business, or establishment in which employed (or employer): O

9-BIRTHPLACE, (State or Country). Va.

PARENTS.

10-NAME OF FATHER. unknown

11-BIRTHPLACE OF FATHER. (State or Country). "

12-MAIDEN NAME OF MOTHER. uhknown

13-BIRTHPLACE OF MOTHER. (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. R.A. Elliott

(Address) 1725 Eastlander

15-

Filed, 192 Registrar.

JUL 14 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 11/23 (Month) (Day) 192 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Acute Cardiac Dilitation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(Duration) yrs. mos. ds.

(Signed) J S Y Coleman M. D.
(Coroner)

7/13/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Laurel Cemetery July 14 1923

20-UNDERTAKER. ADDRESS
Mrs R.A. Elliott 1725 Eastlander

This is very important. See instructions on back of certificate. Spaces must be filled in, so that it may be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should

S·A·F·E

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77502

CERTIFICATE OF DEATH.

31 D77502

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 ST. Municipal Tuberculosis Hospital WARD)

2-FULL NAME Thomas woodall

(a) RESIDENCE NO. 504 S. 8th st. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 031

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Isaac Woodall

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) England

12 MAIDEN NAME OF MOTHER Deborah Andrews

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) England

Informant Hospital Records
M.T.H.

7-12-23

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1923, to July 12, 1923, that I last saw him alive on July 12, 1923, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? NO Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Tb in sputum

(Signed) Francis Delaglaecch M. D.

(Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	July 14 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe

...ease in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
...is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77503

CERTIFICATE OF DEATH.

47 D77503

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 645 Vine ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucinda Woodcock

(a) RESIDENCE NO. 645 Vine ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elias Woodcock

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE 68 Years — Months — Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER John Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Catherine Hardegree

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Mrs. Woodcock

(Address) 645 Vine St.

15 JUL 14 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/12 1923

17 I HEREBY CERTIFY, That I attended deceased from 7/6 1923 to 7/12 1923, that I last saw h alive on 7/12 1923, and that death occurred, on the date stated above, at 3:30 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma breast — 6 mos

Cerebral Hemorrhage + Paralysis — 6 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Burkett M. D.

13 1923 (Address) 2134 Dol a

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

md Auburn Cemetery July 15 1923

20 UNDERTAKER — ADDRESS

John H Toadvine 1421 Hill

IMPORTANT: Every item of information should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of DISEASE is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77504
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

129 ✓ D77504
REGISTERED NO.

CITY OF BALTIMORE: (No. 1840 Fremont St., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Irons

(a) RESIDENCE NO. 1840 Fremont St., WARD
(Usual place of abode) dont
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mintie Irons

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE 65	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer) Day labor
(c) Name of employer —

9 BIRTHPLACE (city or town) Talbot Co. Md
(State or country)

PARENTS

10 NAME OF FATHER Stephen Irons
11 BIRTHPLACE OF FATHER (city or town) Talbot Co. Md.
(State or country)
12 MAIDEN NAME OF MOTHER Margaret Chase
13 BIRTHPLACE OF MOTHER (city or town) Talbot Co. Md.
(State or country)

14 Informant Mintie Irons
(Address) 1840 Fremont St.

JUL 14 1923

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 - 1923

17 I HEREBY CERTIFY, That I attended deceased from July 8 - 1923, to July 12 - 1923, that I last saw h[illegible] alive on July 12 - 1923, and that death occurred, on the date stated above, at 1-20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

chot — yrs. 3 mos ds.
(duration)

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Gen. urine

(Signed) Chas. L. McCarthy, M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	July 15 1923
20 UNDERTAKER Frederick A. Schaub	ADDRESS 343 Fremont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77505

CERTIFICATE OF DEATH.

161-001 D77505

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4812 Liberty Heights St. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Nisbet

(a) RESIDENCE NO. 4812 Liberty Heights St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 13-1923

7 AGE Years Months Days If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Kate Lynch

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant E. Lynch

(Address) 4812 Liberty Heights

JUL 14 1923 Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1923

17 I HEREBY CERTIFY, That I attended deceased from July 13 1923 to July 13 1923

that I last saw h— alive on July 13 1923

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth. Caused by rupture of Umbilical Cord.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Patent uterus

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Signs of Preg.

(Signed) Thos. H Phillips M. D.

19 (Address) 230 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

20 UNDERTAKER — ADDRESS

TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77506

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D77506

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1415 N Lumbard ST., 14 WARD)

2-FULL NAME Dorothy C Carson

(a) RESIDENCE NO. 1415 N Lumbard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. 5 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 28 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas W. Carson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Emma Frazer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Chas Carson

(Address) 1415 N Lumbard

15 Filed JUL 14 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1923

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1923, to July 13, 1923, that I last saw her alive on July 13, 1923, and that death occurred, on the date stated above, at 7 15 P m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) M A O'Neill M. D.

7/14. 1923 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	July 16 1923
20 UNDERTAKER George D Smith	ADDRESS [illegible]

TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77507

CERTIFICATE OF DEATH.

D77507

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1403 Annapolis Ave St. 25th WARD)

REGISTERED No. C 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa French

(Residence in Baltimore: No. 1403 Annapolis Ave St. Life yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, February (Month) 3 (Day) 1858 (Year)

7-AGE, 65 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Henry Valentine

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Lissie Ellers

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Lee French

(Address) 1403 Annapolis Ave

15- Filed JUL 14 1923 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 13 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1923, to July 13 1923, that I saw her alive on July 13 1923, and that death occurred, on the date stated above, at 6:15 A m.

The CAUSE OF DEATH* was as follows:

Acute Myocardial Insufficiency

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis ?

(Duration) ? yrs. mos. ds.

(Signed) H Lawrence Wheeler M. D.

July 13, 1923 (Address) Lansdowne P.O.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cem	July 16, 1923
20-UNDERTAKER George J. Smith	ADDRESS 1532 Harlem

Please read instructions on back of certificate. PHYSICIANS should state properly classified. Exact statement of OCCUPATION is very

Spec—12-23-21—E.B.R.S.—400 Bks.

D77508 HEALTH DEPARTMENT—CITY OF BALTIMORE D77508

58-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2110 East Pratt Street St., 1 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ida J. Goetz

(a) Residence No. Same as above at 2110 Pratt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 9 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Goetz

6-DATE OF BIRTH (month, day and year) Oct 4 1869

7-AGE. 54 yrs. 9 mos. 7 ds. If LESS than 1 day ... hrs. or ... min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, John Geiger

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Weber

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Charles Goetz

(Address) 2110 East Pratt St.

15- Filed JUL 14 1923 19?

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 13-1923

17- I HEREBY CERTIFY, That I attended deceased from June 6 1923 to July 13 1923

that I last saw h[illegible] alive on July 1 1923

and that death occurred, on the date stated above, at 3.00 A. M.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

6

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of Left Kidney

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic blood

I am (Signed) Abraham Gorb M. D.

, 19 (Address) 2731 Parkwood ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
London Park	July 16 1923

20-UNDERTAKER.	ADDRESS
George Smith	1522 Hollins

ER

Instructions on back of certificates. PHYSICIANS should state CAUSE OF DEATH so that it may be properly classified. Exact statement of OCCUPATION is very important. See

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77509

CERTIFICATE OF DEATH.

74-001 D77509

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Bessie Freney

(a) RESIDENCE. No. Mt Hope Retreat ST., 28th WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? Durin Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, ~~or divorced~~ If ~~husband~~ of (or) ~~wife~~ of Widow of Mr Freney.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
abt	72	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) (?) Ireland

PARENTS

10 NAME OF FATHER Mr. Cahill (?)

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) (?)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) (?)

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md.

15 Filed ..... 19 ..... Registrar

JUL 14 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1923

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1923, to July 12, 1923, that I last saw h.. alive on July 12. 1923, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis. Post Cerebral Hemorrhage

abt (duration) 0 yrs. 6 mos. 0 ds.

CONTRIBUTORY (Secondary) Senile Psychoses

~~abt~~ (duration) 0 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	7/14/23 19
20 UNDERTAKER Henry W. Maas & Son	ADDRESS 805 N. Calvert St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77510

CERTIFICATE OF DEATH.

190D77510

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1605 Argyle ave ST.; 17 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Green

(Residence in Baltimore: No. 1605 Argyle ave St.; 5 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Mar (Month) 4 (Day), 1875 (Year)

7-AGE, 48 yrs. 4 mos. 8 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic duties
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country) Belleview Md

PARENTS.

10-NAME OF FATHER, Lloyd Brummel

11-BIRTHPLACE OF FATHER (State or Country), Maryland.

12-MAIDEN NAME OF MOTHER not known

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas Green (Son)

(Address) 1605 Argyle ave

15-

JUL 14 1923

191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 12 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1923, to July 12 1923, that I saw h[er] alive on July 12 1923, and that death occurred, on the date stated above, at 3.40 p.m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T E Daughtry M. D.

July 12, 1923 (Address) 1602 Pennsylvania ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL, OR REMOVAL, Ft Lord Md

DATE OF BURIAL, July 14, 1923

20-UNDERTAKER Samuel Hensley

ADDRESS 725 N Bedale

IMPORTANT. See instructions on back of certificate. Words should be stated EXACTLY. PHYSICIANS should state terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77511

CERTIFICATE OF DEATH.

N020 18

31 D77511

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1636 Miller ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Scott

(a) RESIDENCE. No. 1636 Miller ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary Scott
(Address) 1636 Miller St

15 JUL 14 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1923

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1923, to July 11, 1923, that I last saw h[illegible] alive on July 11, 1923 and that death occurred, on the date stated above, at 9 1/2 37 m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Delicate Heart (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J. Edward Fisher, M. D.

7-12 1923 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Northumberland Co Va	7/15/23

20 UNDERTAKER Robert F. Williams ADDRESS 1515 McElderry St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77512

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

1 188 03

Registered No. D77512

City of BALTIMORE: (No. Mercy Hosp St., Ward)

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lieutenant white man

(Residence in Baltimore: No. Lieutenant St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	?

6-DATE OF BIRTH.

..... (Month) ..... (Day) 1..... (Year)

7-AGE 65 - about

.....yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country).

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address).....

15-

FILED JUL 14 1923 Registrar.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH. July 6 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

Circumscribed brain accidentally struck by automobile on Road near Towson

6 days (Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) ..... M. D.
(Coroner.)

July 8 1923 (Address) 1057 Bens

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.

PUBLIC CEMETERY July

20-UNDERTAKER. ADDRESS.

Commissioner Health. JUL 14 1923

THE MORGUE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D77513

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77513

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Ernest Williams

(Residence in Baltimore: No. — St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	W	S

6-DATE OF BIRTH.

..... 1.....
(Month) (Day) (Year)

7-AGE. 21 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Lab.
(b) General nature of industry, business, or establishment in which employed (or employer)..... Rd Land

9-BIRTHPLACE, (State or Country). Md.

PARENTS

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country), Orig Irish

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15-

Filed ..... 192.....

G S

Registrar.

JUL 14 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 4
(Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or Inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tetanus following
laceration foot day of
accident on boat "Compton"
about 3 or 4 days
(Duration) ..... yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) ..... yrs. mos. ds.

(Signed) [signature] M. D.
(Coroner)
July 11 192 (Address) 1657 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
PUBLIC CEMETERY	 19
20-UNDERTAKER,	ADDRESS
City please bury	JUL 14 1923

Department of Health
THE MORGUE

Is very important. See instructions on back of certificate. AGE should be stated EXACTLY. PHYSICIANS should state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77514

CERTIFICATE OF DEATH.

7 13

D77514

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 N Chapel ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Berger

(a) RESIDENCE. No. 1008 N Chapel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 27/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Berger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Josephine Dubosky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant John Berger
(Address) 1008 N Chapel

15 Filed JUL 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-13 1923

17 I HEREBY CERTIFY, That I attended deceased from 7-7 1923, to 7-13 1923

that I last saw him alive on 7-12 1923

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Acute Pleurodynia

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pending

(Signed) Fred Burnbo M. D.

7-15 1923 (Address) 600 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL July 15 1923

20 UNDERTAKER Frank Crouch Son — ADDRESS 1906 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77515

CERTIFICATE OF DEATH.

162 D77515

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 S Washington ST., V WARD)

2-FULL NAME Rev Kacperzak

(a) RESIDENCE No. 305 S Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Mal | 4 COLOR OR RACE white | 5 Single, Married, Widowed, or Divorced, (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7/12/23

7 AGE Years Months Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Kazmir Kacperzac

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Helen Tomchack

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Kazmir Kacperzak (Address) 305 S Washington

JUL 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1923

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1923, to July 14, 1923, that I last saw him alive on July 14, 1923, and that death occurred, on the date stated above, at 9 A.m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M D Kaufman, M. D.

July 14 1923 (Address) 1595 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL 7/15 1923

UNDERTAKER William Gallagher

ADDRESS 1118 Eastern

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77516

CERTIFICATE OF DEATH.

43 D77516

1-PLACE OF DEATH Church Home and Infirmary

REGISTERED NO.

CITY OF BALTIMORE: (No. 136 N Broadway ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Bessie Lozinsky

(a) RESIDENCE NO. 2317 E Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 8 mos. ds. How long in U. S., if of foreign birth? 1 yrs. 8 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jake Lozinsky

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Joseph Trinitzky

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rose Trinitzky

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address): 1439 Eastaw

15 Filed JUL 15 1923 ROBERT R. KRAMER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 13 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1923, to July 13, 1923, that I last saw her alive on July 13, 1923, and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Rectum

(duration) yrs. 12 mos ds.

CONTRIBUTORY (Secondary): Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 13 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Cayetano Panettieri, M. D.

, 19 (Address) Church Home Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale | DATE OF BURIAL: July 15 1923

20 UNDERTAKER: Jack Lewis | ADDRESS: 1439 Eastaw

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state AGE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D77517

REGISTERED No. C

D77517

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West End Maly Hospt. St.: 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby girl Butler

(Residence in Baltimore: No. West End Maly Hospt St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)

6-DATE OF BIRTH, July 13 23, 1 (Month) (Day) (Year)

7-AGE, 0 yrs. 0 mos. 0 ds.

If LESS than 1 day, 12 hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), West End Maly Hospl

PARENTS.

10-NAME OF FATHER, Meyer Butler

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Sarah Resnikoff

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E Baltimore

15-

JUL 15 1923

ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 14, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 13 1923 to July 14 1923 that I saw h[illegible] alive on July 14 1923 and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Suffocation

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) none

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Claas A Nerstad M. D.

July 14, 1923. (Address) 421 E Biddle

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Northern circle — DATE OF BURIAL, July 15 1923

20-UNDERTAKER Jack Lewis 1439 E Balto — ADDRESS

Important. See instructions on back of certificate. Information should be stated EXACTLY. PHYSICIANS should state plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Remarks Difficult Labor

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, 6 *yrs.*). For persons who have no occupation whatever, write *None*.

STATEMENT OF CAUSE OF DEATH.—Name, *first*, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid-pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—7-10-21—M&T—1500 Bks.

Brzostek

D77518 HEALTH DEPARTMENT—CITY OF BALTIMORE D77518

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 S Montford ave ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Brzostek

(a) RESIDENCE NO. 613 S Montford ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 14 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frank Brzostek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Bronislawa Siatkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Frank Brzostek

(Address) 613 S Montford ave

15 Filed JUL 15 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1923

17

I HEREBY CERTIFY, That I attended deceased from July 13th, 1923, to July 14, 1923, that I last saw h[illegible] alive on July 14, 1923, and that death occurred, on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows:

Acute Ileo-Colitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Philibert Artigiani, M. D.

19 (Address) 2942 Ezekiel St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 15 1923

20 UNDERTAKER ADDRESS

John M Weber 1843 Banner

CAUSE OF DEATH in plain terms. Every item of information should be stated EXACTLY. PHYSICIANS should state TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77519

D77519

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 629 W. Hamburg ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Amersbach

(a) RESIDENCE NO. 629 W. Hamburg ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 2 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane Amersbach.

6 DATE OF BIRTH (month, day, and year) May 1st 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Leonard Amersbach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Annie Schlagenhoft

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Caroline Balsinger

(Address) 2221 W Lexington St.

15 JUL 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9 - 1923, to July 14 1923, that I last saw h in alive on July 12 1923, and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:

organic heart disease

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) none (duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed) Chester Riland, M. D.

7-14-1923 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn DATE OF BURIAL July 16 1923

20 UNDERTAKER Wm Cook ADDRESS 502 East North ave

IMPORTANT.—ONLY, WITH UNFAILING ACCURACY, AGE should be carefully supplied. AGE should be carefully supplied. AGE should be carefully supplied.

Spec.—1-10-21—M&T—1500 Bks.

D77520 HEALTH DEPARTMENT—CITY OF BALTIMORE D77520

CERTIFICATE OF DEATH. 129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 N Payson ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Hiser Simmons

(a) RESIDENCE NO. 717 N Payson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of George L Simmons

6 DATE OF BIRTH (month, day, and year) Dec 15 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer /

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wallace Hiser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto md

12 MAIDEN NAME OF MOTHER Mary Kroft

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Geo L Simmons

(Address) 717 N Payson St

15 ROBERT R. KRAUTER, Registrar.

JUL 15 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1923, to July 14, 1923, that I last saw her alive on July 13, 1923, and that death occurred, on the date stated above, at 9 10 a. m.

The CAUSE OF DEATH* was as follows:

Pyemia — 2 mos.

Chr. Parenchymatous Nephritis. 5 mos.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Eclampsia 6 mos. abscess Parotic gland 2½ mos.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Opened abscess. Date of

Was there an autopsy? no

What test confirmed diagnosis? usual.

(Signed) Geo A Strauss, M. D.

7/14, 1923 (Address) 1800 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 7/17 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E Northern

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be properly classified. It may be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ D77521

77521

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 440 E. 28th ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Andrew Blackburn

(a) RESIDENCE NO. 440 E 28th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elsie Lord

6 DATE OF BIRTH (month, day, and year) Sept 14 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	24	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) B

(c) Name of employer B & O R.R.

9 BIRTHPLACE (city or town) (State or country) Balt.

PARENTS

10 NAME OF FATHER Arthur H. Blackburn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Bessie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Arthur H. Blackburn (Address) 440 E 28th St.

15 JUL 15 1923 ROBERT R. KRAUTER, Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to July 13, 1923.

that I last saw him alive on July 13, 1923.

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs & Symptoms

(Signed) Walter A Cole, M. D.

July 14, 1923 (Address) 543 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet DATE OF BURIAL July 16 1923

20 UNDERTAKER New book ADDRESS 502 E Northern

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. All information should be carefully supplied, so that it may be properly classified. Please write in plain terms, so that it may be understood. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77522

CERTIFICATE OF DEATH.

D77522

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2314 Penna av ST., 13 WARD)

2-FULL NAME Mrs Kirtie E. Klein

(a) RESIDENCE NO. 2314 Penna av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 21 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 637

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Ryley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Sarah Champion

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Michael J. Klein

(Address) 2314 Penna av.

15 Filed JUL 15 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1923

17 I HEREBY CERTIFY, That I attended deceased from July 10 1923 to July 13 1923.

that I last saw her alive on July 13 1923.

and that death occurred, on the date stated above, at 1300 m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage Tobacco Pneumonia, acute

Heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis of lung (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Circumstantial

(Signed) Edward [illegible] M. D.

(Address) 1605 W Pratt av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park July 16 1923

DATE OF BURIAL

ADDRESS

20 UNDERTAKER Wm Cook 501 E. N. Ave

N. B.—WRITE PLAINLY, WITH INK. AGE must be properly classified and entered in proper column. Information should be carefully supplied, so that it may be properly classified and entered in proper column. Information should be carefully supplied, so that it may be used in terms, so that it may be used in terms, so that it may be used in terms

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Was under treatment of
Dr Alexander for ten
days. Had ruptured
tetter with chill night
of July 8/23 while on
picnic; developed into
Lobular Pneumonia July 11/23
Very anemic & Made no
response to treatment.

Spec.—1-10-21—M&T—1500 Blks.

D77523

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002

159 D77523

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3456 Seneca ST., 13 WARD)

2-FULL NAME Infant Baldwin

(a) RESIDENCE No. 3456 Seneca ST., ... WARD ...
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	C

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas P. Baldwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Beatrice C Mahaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Mahaney
(Address) 3456 Seneca St

15 JUL 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1923

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1923, to July 14, 1923, that I last saw h[illegible] alive on July 14, 1923, and that death occurred, on the date stated above, at 8-30 A m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

Foramen Ovale not Closed

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Fair, M. D.

, 19 (Address) 12 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden	July 16 1923
20 UNDERTAKER	ADDRESS
Horace M. Burgee	363 Wells St

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77524

REGISTERED NO. 129 D77524

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2725 Jefferson St ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Van Newkirk.

(a) RESIDENCE NO. 2725 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/8/1884.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	39	I	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER H: C: W: Kumlehn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Burckhardt

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant William Kumlehn
(Address) 2725 Jefferson St

15 Filed JUL 15 1923 ROBERT R. KRAUTER, Register
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/12/1923

17 I HEREBY CERTIFY, That I attended deceased from May - 29 , 1923 , to July - 12 , 1923 ,

that I last saw h alive on " 12 , 1923

and that death occurred, on the date stated above, at 5.25 P.M.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. — mos — ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) [illegible] , M. D.

(Address) 125 W Mt Vernon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 8/16/23

20 UNDERTAKER John Ullrich ADDRESS 2008 Orleans St

N. B.—WRITE PLAINLY, WITHOUT ABBREVIATIONS. AGE should be carefully supplied. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77525

CERTIFICATE OF DEATH.

3 ✓

D77525

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 411 E. Hamburg ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Young

(a) RESIDENCE NO. 411 E Hamburg ST., 23 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFAILING INK. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Widowed.

5a If married, widowed, or divorced (or) WIFE of the late, William Young.

6 DATE OF BIRTH (month, day, and year) August, 11, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64.	11.	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer) 00

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER Johnathan Forrest.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Howard Co. Md.

12 MAIDEN NAME OF MOTHER Henrietta Kenol

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Howard Co. Md.

14 Informant Mary E. Airey,
(Address) 411 E. Hamburg ST.

15 JUL 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7.14 1923

17 I HEREBY CERTIFY, That I attended deceased from 7.1. 1923, to 7.14 1923

that I last saw h er alive on 7.14 1923 and that death occurred, on the date stated above, at 1.a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Gen Debility
(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr. Turlington, M. D.

7.14. 1923 (Address) 102 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sod Shepard bem	July 16, 1923
20 UNDERTAKER	ADDRESS
A. Howard Evans	1428 S. Charles St

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12-9 D77526

REGISTERED NO. C

D77526

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 W.Clement st. ST.: 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert G.W.Parson

(Residence in Baltimore: No. 121 W.Clement

St.: 50 yrs.. 1 mos. 11 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June 2/1873. (Month) (Day), 1 (Year)

7-AGE, 50 yrs. 1 mos. 11 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work..... Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER. Robert Parson

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine Parson

(Address) 121 W.Clement st.

15- ROBERT R. KRAUTER, Burial Permit Clerk.

JUL 15 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 13/23. (Month) (Day), 191... (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb.1/23 191, to July 13/23 191, that I saw him alive on July 13/23 191, and that death occurred, on the date stated above, at 5.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis.

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Theus Waddell M. D.

July 14/23. (Address) 933 Hanover st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cem. DATE OF BURIAL. 7/16, 1923

20-UNDERTAKER L. H. McCully ADDRESS 130 E. Fort

N.B.—Every item of information should be carefully written, so that it may be properly CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77527 ✓

D77527

CERTIFICATE OF DEATH.

71-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 533 E. 20th ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo G. Kelly

(a) RESIDENCE NO. 533 E. 20th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24-1895

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
28		19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas Parts Co Maryland

PARENTS

10 NAME OF FATHER Thos. J. Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie F. Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Thos J. Kelly (Address) 533 E. 20th St

15 FILED JUL 15 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1923

17 I HEREBY CERTIFY, That I attended deceased from July 12 1923 to July 13 1923.

that I last saw h— alive on July 13 1923.

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Hemorrhage of Coronary Sinus

& Meningitis (Septic)

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. F. Bruney M. D.

19 (Address) 1923 Texas Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Joseph Cemetery Texas Md — DATE OF BURIAL 7/16 1923

20 UNDERTAKER Chas H. Evans & Son — ADDRESS 158 N. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. Age should be properly classified. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

L

165015 12 45 p.m. D77528

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D77528

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. 6 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lester Wilkes

(a) RESIDENCE NO. 1614 Mullikan St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. unknown How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	14			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): SC

PARENTS

10 NAME OF FATHER Thomas Wilkes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va ?

12 MAIDEN NAME OF MOTHER Hattie Robins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUL 15 1923 ROBERT R. KRAUTER, Registrar. Burial Permit issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1923

17

I HEREBY CERTIFY, That I attended deceased from July 11, 1923 to July 12 1923.

that I last saw him alive on July 12, 1923.

and that death occurred, on the date stated above, at 12 45 p.m.

The CAUSE OF DEATH* was as follows:

Tetanus —

deep injury of palm of left hand by fish-hooks.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. R Bugg M. D.

(Address) Johns Hopkins Hospital 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and 12) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Auburn Cemetery	July 15 1923
20 UNDERTAKER Mrs Robert F Elliott	ADDRESS 1725 Ashland Av

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be given in CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Czernicka)

77548 D77529

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

124 D77529

1-PLACE OF DEATH 2710

CITY OF BALTIMORE: (No. ~~2710~~ Dillon — ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Czernicka

(a) RESIDENCE NO. 2710 Dillon St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	.	.	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) ..... Poland
(State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Poland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Poland

14 Informant Anna Wisniewska
(Address) 2610 E. Dillon St

15 JUL 16 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12. 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to July 12, 1923, that I last saw her alive on July 12, 1923 and that death occurred, on the date stated above, at 11-30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Frances S Tilton M. D.

7/25 1923 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem	July 16 1923
20 UNDERTAKER	ADDRESS
Stephen Swiatkowski	1005 Kenwood Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated in every case. Information should be carefully supplied. AGE should be properly classified. Exact CAUSE OF DEATH in plain terms, so that it may

Cor.—1-12-23—M&T—100 Bks.

77529
D77530

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1919 D77530

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Johns Hopkins Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John B. Shrewsbury

(a) RESIDENCE: NO. Egeria Colliery Co. ST., W. Va. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 29 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	5	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Policeman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Egeria Coal Co W. Va

PARENTS

10 NAME OF FATHER John G. Shrewsbury

11 BIRTHPLACE OF FATHER (city or town) (State or country) Egeria W. Va

12 MAIDEN NAME OF MOTHER Ella Meadows

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Colliery Co W. Va

14 Informant W. F. Shrewsbury (Bro)
(Address) Baxter W. Va

15 JUL 15 1923 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Sepsis of spinal cord
7th cervical region

(Duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bullet wound.

(Duration) yrs. mos. ds.

(Signed) J. S. Potter (M.D.) M. D.
(Coroner.)

7/15 1923 (Address) 508 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Herndon W. Va. DATE OF BURIAL July 17. 1923

20 UNDERTAKER Wm. G. Schaeffer ADDRESS 1816 E. Mun

N. B.—WRITE PLAINLY. Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be understood. ATTENTION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.K.S.—400 Bks.

D77531

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D77531

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 916 E.Eager St. St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME....Micheal T. Jennings,

(a) Residence No...916 E. Eager ST. St.,.....Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Mairred

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Catherine Jennings

6-DATE OF BIRTH (month, day and year) Sept. 29, 1865.

7-AGE. 57 yrs. 9 mos. 14 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Track Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Penn., R.R.,

(c) Name of employer Penn., R. R. Co.

9-BIRTHPLACE (city or town) (State or Country). Ireland,

PARENTS.

10-NAME OF FATHER, Thomas Jennings,

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland.

12-MAIDEN NAME OF MOTHER, Winerford Conroy.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland,

14- (Informant) Mrs. Catherine Jennings.

(Address) 916 E.Eager St.

15- Filed JUL 16 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 12-1923

17- I HEREBY CERTIFY, That I attended deceased from July 6— 1923 to July 12, 1923

that I last saw him alive on July 12 1923 and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Mary F Vaughan M. D.

7-14-1923 (Address) 1028 Tilley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL.
New Cathedral	July 16/23
20-UNDERTAKER.	ADDRESS
Elmer W. Conklin	924 E.Eager St

N. B.—WRITE PLAINLY. WITH... should be carefully supplied. AGE should be... in plain terms, so that it may be properly classified. Exact... instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77532

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D77532

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1821 Hanneman Ave ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Butcher

(a) RESIDENCE. NO. 1821 Hanneman ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Mar 7 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William Butcher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Marie Melichar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant William Butcher

(Address) 1821 Hanneman

15 Filed NOV 16 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1 1923 to July 14 1923

that I last saw h[illegible] alive on July 14 1923 at 1130 a. m.

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Acute Glomerulitis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) [illegible] M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 16 1923
20 UNDERTAKER	ADDRESS
Paul Graeber & Son	1706 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. AGE should be properly classified, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77533

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77533

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 Central ave ST. 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E Litchfield

(a) RESIDENCE. No. 1305 Central ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	70	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Geo. Town MD

PARENTS

10 NAME OF FATHER Hezekiah Burris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Geo. Town MD

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Florence Bricar

(Address) 1305 N Central ave

15 Filed JUL 16 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1923

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1923, to July 13, 1923, that I last saw her alive on July 13, 1923, and that death occurred, on the date stated above, at 4.30 p m.

The CAUSE OF DEATH* was as follows:

Apoplexy Cerebral

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H Argus M. D.

, 19 (Address) 1603 N Broadway

*State the Disease Causing Death, or in deaths from Violence, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July 16 1923
20 UNDERTAKER Henry Lutz	ADDRESS 1203 N Broadway

N. B.—WRITE PLAINLY, WITH INK. All items must be properly supplied. Age should be carefully supplied. Age should be carefully supplied. Age mation should be carefully supplied, so that it may be given in plain terms, so that it may CAUSE OF DEATH in plain terms, so that it may be given in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77534

HEALTH DEPARTMENT—CITY OF BALTIMORE D77534

CERTIFICATE OF DEATH.

108-001

1-PLACE OF DEATH Hospital for the Women of Maryland REGISTERED NO.

CITY OF BALTIMORE: (No.) Lafayette Ave & Johns ST., 27 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine High Travers Davidson Trail

(a) RESIDENCE NO. 110 Elmhurst Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas S. Trail.

6 DATE OF BIRTH (month, day, and year) July 22, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20	11	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Oswego (State or country) New York.

PARENTS

10 NAME OF FATHER Percy Davidson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Margaret Travers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs Margaret Davidson (Address) 110 Elmhurst Road

15 Filed JUL 19 1923 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1923

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1923, to July 14, 1923, that I last saw her alive on July 13, 1923, and that death occurred, on the date stated above, at 1:25 a m.

The CAUSE OF DEATH* was as follows:

Pericarditis with effusion
(Etiology unknown)
(SECONDARY)

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? Yes Date of June 6, 1923

Was there an autopsy? Yes - partial thoracic

What test confirmed diagnosis? Paracentesis pericardii

(Signed) Norman E. Tannenbaum M. D.

, 19 (Address) Hospital for the Women of Maryland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md | DATE OF BURIAL July 17 1923

20 UNDERTAKER John C. Mitchell | ADDRESS 1201 Way

N. B.—WRITE PLAINLY, WITH UNFAILING. AGE should be properly classified. mation should be carefully supplied. so that it may be CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D77535 HEALTH DEPARTMENT—CITY OF BALTIMORE D77535

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3119 Guilford St., 12 Ward)

Registered No. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A Allen

(a) Residence No. 3119 Guilford ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced, (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Augustus M. Allen

6-DATE OF BIRTH (month, day and year): Jan 24 1866

7-AGE: 57 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Ladies Lady.

(b) General nature of industry, business, or establishment in which employed (or employer): Servants Dept State.

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore Md

PARENTS.

10-NAME OF FATHER: John Fitscher

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany.

12-MAIDEN NAME OF MOTHER: Mary E. Ackler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore Md

14-

(Informant): Lewis A Walkins

(Address): 3119 Guilford ave

15-

Filed 1923 19 July 21 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 13-1923

17- I HEREBY CERTIFY, That I attended deceased from July 3, 1923, to July 13, 1923, that I last saw h. alive on July 13, 1923, and that death occurred, on the date stated above, at 10.45 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 3 hrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) John A Grant M. D.

, 19 (Address) 101 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL.
Greenmount Park Cem	July 16, 1923
20-UNDERTAKER.	ADDRESS
John O. Mitchell	1201 W Fayette

N. B.—WRITE PLAINLY. All questions should be carefully supplied. AGE should be given in plain terms, so that it may be properly classified. Exact instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

94-001 D77536

D77536

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 147 W. Montgomery ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma L. Slagle

(a) RESIDENCE No. 147 W. Montgomery ST., 22 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE el

5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 19 1923

7 AGE Years Months 6 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER James Slagle

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Annie Chase

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Annie Slagle (Address) 147 W. Montgomery

15 JUL 16 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/15 1923

17 I HEREBY CERTIFY, That I attended deceased from 7/14 1923, to 7/15 1923.

that I last saw h[illegible] alive on 7/15 1923, at 11 P. m.

and that death occurred, on the date stated above, at

The CAUSE OF DEATH* was as follows:

Catarrhal croup 2 ds.

CONTRIBUTORY (Secondary) Bronchitis (duration) yrs. mos. 2 ds.

Acute

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of ——

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Guy Bowley, M. D.

7/15 1923 (Address) 908 Eohart St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Ct DATE OF BURIAL July 16 23

20 UNDERTAKER D. L. Brown and Son ADDRESS 108 W Monta

N. B.—WRITE PLAINLY, WITH ONE [illegible] AGE should be carefully supplied, so that it may be properly classified. Information should be carefully supplied in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history
Not dep

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77537

CERTIFICATE OF DEATH.

33 D77537
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 827 Leadenhall ST.: 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Crawford

(a) RESIDENCE. No. 827 Leadenhall ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wedley Crawford

6 DATE OF BIRTH (month, day, and year) Feb 2 - 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Sarah Heard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Agustus Crawford
(Address) 827 Leadenhall ave

Filed JUL 16 1923 L. A. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to July 13, 1923, that I last saw her alive on July 13, 1923, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis

(duration) About 6 weeks ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. H. Cassell M. D.

July 16, 1923 (Address) 140 William

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	July 16 1923
20 UNDERTAKER	ADDRESS
S. S. Brown & Son	108 N Monty

N. B.—WRITE PLAINLY. Information should be carefully supplied, so that it may be permanent. CAUSE OF DEATH in plain terms, so that TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77538

CERTIFICATE OF DEATH.

12 9 D77538

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST., 9 WARD)

2-FULL NAME Mrs. Helen E. Shipley

(a) RESIDENCE NO. 1816 W. Lombard ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Shipley

6 DATE OF BIRTH (month, day, and year): Apr 3 - 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Wm Irwin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mulenowre

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mr Jos L Shipley

(Address): 1816 W Lombard St.

15 Filed JUL 16 1923 J. L. R. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/14/23 19

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1923, to July 14, 1923, that I last saw h e alive on July 14, 1923, and that death occurred, on the date stated above, at 3:20 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary): Chron. Interstitial Nephritis

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Blood urea. P.S. Symptoms

(Signed) J. A. Bekewirth M. D.

, 19 (Address) St. J. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	July 17, 1923
20 UNDERTAKER: Chas J Gaynor & Co	ADDRESS: 901 Madison Ave

MARGIN MUST BE LEFT BLANK—THIS IS A PERMANENT RECORD. PHYSICIANS

N. B.—WRITE PLAINLY, WITH UNFADING INK—All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77539 D77539

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1824 Dult ST. Pul 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Ella Cooke

(a) RESIDENCE. No. 1824 Dult ST., 24 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4.23 1921

7 AGE 2 Years 2 Months 24 Days. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Jas. Lemuel Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Matilda E. Cooke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Jas Lemuel Cook 1824 Dult St.

15 JUL 16 1923 J. L. K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/15 1923

17 I HEREBY CERTIFY, That I attended deceased from 7.8 1923 to 7/15 1923

that I last saw h[illegible] alive on 7/15 1923

and that death occurred, on the date stated above, at 12.1 M. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis (duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. 8 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L. J. Linthicum M. D.

19 (Address) 102 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem — DATE OF BURIAL: July 16 1923

20 UNDERTAKER: J. Edw. F. Cowan & Son — ADDRESS: 908 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful to see that the information should be carefully supplied. AGE should be stated EXACTLY. Exact statement (of OCCUPATION) CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement may be made on back of certificates. See instructions on back of certificates. TION is very important.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77540

CERTIFICATE OF DEATH.

D77540

REGISTERED NO. 161 001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1st House west side S. Baker ave. Parkville WARD)

2-FULL NAME Albert Earl Clark

(a) RESIDENCE NO. 1st House west side S. Baker ave. Parkville WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred . yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): May 16th 1922

7 AGE — Years: — Months: 1 Days: 29 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Maryland

PARENTS

10 NAME OF FATHER Albert E. Clark

11 BIRTHPLACE OF FATHER (city or town) Balto. Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Adele Pickles

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Albert E. Clark (Address) Parkville Md.

15 JUL 16 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1923

17

I HEREBY CERTIFY, That I attended deceased from July 11 1923 to July 15 1923 that I last saw him alive on July 15 1923, and that death occurred, on the date stated above, at 4.25 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Premature birth (10th month)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) A. W. Bacon M. D.

19 (Address) Parkville, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wauch Cemetery — DATE OF BURIAL: July 16 1923

20 UNDERTAKER: H. H. Lissauer Sons — ADDRESS: Fallston

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77541 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 1 D77541 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Day View St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert R. Rhodes

(Residence in Baltimore: No. 4622 Freemount ave St.; yrs..... mos..... ds.)

WRITE PLAINLY, WITH INK.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. July 31st 1869 (Month) (Day) (Year)

7-AGE. 54 yrs. — mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Meat Cutter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Bel Air Md

PARENTS.

10-NAME OF FATHER. Wm. D. Rhodes

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Margaret E. Skinner

13-BIRTHPLACE OF MOTHER, (State or Country). Bel Air

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. J. Wilson Poisal

(Address) Ellicott City, Md

15. JUL 16 1923 J. L. K. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 15th 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jno. B. Horton M. D. (Coroner.)

July 16 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal, or Homicidal. Bel Air Md

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Greenmount Cem DATE OF BURIAL. July 16 1923

20-UNDERTAKER. Robert Brooks & Son ADDRESS Calhoun Hollins st

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77542 D77542

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1730 Carlisle Ave ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Vaughans

(a) RESIDENCE NO. 1730 Carlisle Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 8 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 1, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince George Co. Va

PARENTS

10 NAME OF FATHER Walter Vaughans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince George Co Va

12 MAIDEN NAME OF MOTHER Lottie Claiborne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince George Co Va

14 Informant Walter Vaughans (Address) 1730 Carlisle Ave

15 Filed JUL 16 1923, 19 J. L. R. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1923, to July 14, 1923, that I last saw him alive on July 14, 1923, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) — mos. — ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. A. Powell, M. D.

July 16, 1923 (Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	July 16 1923
20 UNDERTAKER	ADDRESS
Mrs. R. A. Elliott	1125 Eastlander

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77543

CERTIFICATE OF DEATH.

41 D77543

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 511 N. Bond ST., 7 WARD)

2-FULL NAME George Reynolds

(a) RESIDENCE NO. 511 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

MARKING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should make N. B.—WRITE PLAINLY, WITH UNFADING INK—The information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Reynolds

6 DATE OF BIRTH (month, day, and year) August 28 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker 203

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Vare

9 BIRTHPLACE (city or town) (State or country) Martinique West Indies

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Martinique

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary E. Reynolds (Address) 511 N. Bond St.

15 JUL 16 1923 Filed E. L. K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1923, to July 12, 1923, that I last saw h[illegible] alive on July 12, 1923, and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Infected wound of finger

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Balto, Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. C. Robinson M. D.

(Address) 1520 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 16 1923
20 UNDERTAKER	ADDRESS
Mac R. Co. Elliott	1116 Carlton

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77544

CERTIFICATE OF DEATH.

31 D77544

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 W. Fay ave ST., 11 WARD)

2-FULL NAME Ruth Forbes.

(a) RESIDENCE NO. 711 W. Fay ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 27 1910.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	13	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliz Forbes

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Eliz Forbes (Address) 711 Fay ave

15 JUL 16 1923 J. S. R. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14th 1923

17 I HEREBY CERTIFY, That I attended deceased from May 19th 1923 to July 14th 1923, that I last saw him alive on July 9th 1923, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 711 W. Fay ave.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

(Address) 724 Mun.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL 7/16 1923

20 UNDERTAKER Emil Kennedy ADDRESS W. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful in filling out this certificate. AGE should be stated EXACTLY. PHYSICIANS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77545 ✓ 129 D77545

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: No. 524 W. Lanvale ST., 7 WARD)

2-FULL NAME Lucy Turner

(a) RESIDENCE No. 524 W. Lanvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN MUST NOT BE CUT OFF—THIS IS A PERMANENT RECORD. PHYSICIANS should make N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown 186?

7 AGE — Years: 55 — Months: — — Days: — — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cook.
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): King George Co Va

PARENTS
10 NAME OF FATHER: Unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown
12 MAIDEN NAME OF MOTHER: Katy Glascoe
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Chas. Turner
(Address): 524 W. Lanvale St.

15 Filed JUL 16 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 13 1923

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1923, to July 13, 1923.
that I last saw h[illegible] alive on July 13, 1923
and that death occurred, on the date stated above, at 1 A.M. m.
The CAUSE OF DEATH* was as follows:

Chr. Interstitial nephritis
(duration) yrs. 6 mos. ds.
CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) Chas P. Davis M. D.
July 14, 1923 (Address) 1504 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: McCaubrys Cem.
DATE OF BURIAL: 7/16 1923
UNDERTAKER: Samuel S. Hemsley
ADDRESS: W. Balto.

Spec.—1-10-21—M&T—1500 Bks.

D77546

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 D77546

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 S. 4th St. WARD) No

2-FULL NAME Margaret V. Williams

(a) RESIDENCE NO. 704 S. 4th St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female — 4 COLOR OR RACE White — 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George T. Williams

6 DATE OF BIRTH (month, day, and year) Mar 1881

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
42	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Biggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Wayne Co.

12 MAIDEN NAME OF MOTHER Matilda —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Wayne Co.

14 Informant George T. Williams (Address) 704 S. 4th St.

15 Filed JUL 16 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1 1923 to July 14 1923

that I last saw h[illegible] alive on July 13 1923

and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 17 1923

20 UNDERTAKER Phillips Herwig

ADDRESS 2846 Orleans St

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77547 D77547

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1217 N. Patterson Park Ave. St.; 8 Ward)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Laura V. Redmond

(Residence in Baltimore: No. 1217 N. Patterson Park Ave. Street)

67 yrs., 2 mos. 10 ds.)

WRITE PLAINLY, WITH LEAD PENCIL. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	White	Widow

6-DATE OF BIRTH. May (Month) 4 (Day), 1856 (Year)

7-AGE. 67 yrs. 2 mos. 10 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home-keep
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Thomas Mills

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER —

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice V. Redmond

(Address) 504 N. Eutaw St

15-

Filed JUL 16 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 14 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 10 1923, to July 14 1923, that I saw h- or alive on July 13 - 1923 and that death occurred, on the date stated above, at 6.45 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Int. Nephritis

(Duration) yrs. 4 mos. 3 ds.

(Signed) Laura V. Redmond M. D.

7/15 1923 (Address) 2616 Oakmont Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Loudon Pk	7/17, 1923
20-UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans

Spec.—1-10-21—M&T—1500 Bks.

164877548 HEALTH DEPARTMENT—CITY OF BALTIMORE 16-007D77548

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 2

2-FULL NAME Luis Cirsette

(a) RESIDENCE NO. 203 S. Exeter ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Jan 6 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	1	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Joe Cirsette

11 BIRTHPLACE OF FATHER (city or town) Italy
(State or country)

12 MAIDEN NAME OF MOTHER Marie Guglielotta

13 BIRTHPLACE OF MOTHER (city or town) Italy
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 Filed JUL 16 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1923, to July 15, 1923, that I last saw him alive on July 15, 1923 and that death occurred, on the date stated above, at 10 20 A. m.

The CAUSE OF DEATH* was as follows:

Acute bacillary dysentery

(duration) 0 yrs. 1 mos 0 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 0 yrs. 0 mos. 4 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of —

Was there an autopsy? No. Blood agglutination of dysentery organism.

What test confirmed diagnosis?

(Signed) William H. F. Wartham, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Co DATE OF BURIAL July 16 1923

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

WARNING—THIS IS A PERMANENT RECORD. PHYSICIANS should write PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should write PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should write PLAINLY, WITH UNFADING INK. AGE

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77549

CERTIFICATE OF DEATH.

14-001

14 D77549

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3201 Guilford Ave St.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Maria Gale

(Residence in Baltimore: No. 3201 Guilford Ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Single

6-DATE OF BIRTH, Unknown (Month), ... (Day), 1 (Year)

7-AGE, about 90 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Teacher
(b) General nature of industry, business, or establishment in which employed (or employer): (Retired)

9-BIRTHPLACE, (State or Country), Do not know

PARENTS.

10-NAME OF FATHER. Do not know

11-BIRTHPLACE OF FATHER (State or Country). Do not know

12-MAIDEN NAME OF MOTHER Do not know

13-BIRTHPLACE OF MOTHER (State or Country). Do not know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Lula Barnes

(Address) 3201 Guilford Avenue

15- JUL 16 1923 Filed ....., 191..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 15 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 1921, to July 8 1923, that I saw h[illegible] alive on July 8 1923, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

[illegible] Hemorrhage
[illegible]
(Duration) 2 yrs. 5 mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

July 15, 1923 (Address) 253 [illegible]

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St. John's Cem. Waverly DATE OF BURIAL, 7/17, 1923

20-UNDERTAKER Henry W. Mears & Son ADDRESS 805 N. Calvert

WRITE PLAINLY, WITH INK. Do not use pencil. Fill in all blanks. If unknown, or not applied. AGE should be carefully supplied. PLACE OF DEATH must be stated EXACTLY. OCCUPATION is very important.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77550

CERTIFICATE OF DEATH.

14-001 D77550

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 429 E Fairvale ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Peterson

(a) RESIDENCE. No. 429 E Fairvale ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Peterson

6 DATE OF BIRTH (month, day, and year) Dec 1 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Pa

PARENTS

10 NAME OF FATHER Phiffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Pa

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York Pa

14 Informant John Peterson
(Address) 1429 E Fairvale St.

15 JUL 16 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13th 1923

17

I HEREBY CERTIFY, That I attended deceased ~~from~~ from June 30 1923 to — 19

that I last saw h~~er~~ alive on July — 6th 1923.

and that death occurred, on the date stated above, at 5:30 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy
Cerebral Hemorrhage
Sudden when found dead 15 Minutes
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) Wilmer Brinton M D

19 (Address) 1. W. Cor Calvert & Preston

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: July 16 1923

20 UNDERTAKER: E A Wiedefeld Jr — ADDRESS: 501 E 22

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful that information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Frances Strzegowski.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77551

14-001 D77551

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 Lacayt ST., 7 WARD)

2-FULL NAME Mrs Frances Strzegowski

(a) RESIDENCE No. 1607 Lancaster ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nicholas Strzegowski.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Peleca Strzegowski 1607 Lancaster St.

15 Filed JUL 16 1923 G.G. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1923

17 I HEREBY CERTIFY, That I attended deceased from July 2nd, 1923, to July 11th, 1923, that I last saw h alive on July 11th, 1923, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1607 Lancaster St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Walter W. Schmidthal, M. D.

, 19 (Address) 2323 Callaud Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus, DATE OF BURIAL 7/18-1923

20 UNDERTAKER M. F. Sadowski ADDRESS 905 S Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful to see that the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77552

CERTIFICATE OF DEATH.

31 / D77552

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 920 S. Binney ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madaline Friedel

(a) RESIDENCE No. 920 S. Binney ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 12-1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER August Friedel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary Noon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant August Friedel

(Address) 920 S Binney St.

JUL 16 1923 L. R. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to July 13, 1923, that I last saw her alive on July 13, 1923 and that death occurred, on the date stated above, at 7 10 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

contributory unknown

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No Specimen

What test confirmed diagnosis? Mr Mc Avoy

(Signed) M. D.

7/14 1923 (Address) 829 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Oak Lawn Cemetery July 17 1923

20 UNDERTAKER — ADDRESS

A. Sander & Sons 1710 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIAN'S CERTIFICATE should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. It may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec. 1-1931-MS — 1500 Blks.

D77553

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77553

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 S. Wolfe ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Wojciechowski

(a) RESIDENCE NO. 112 S. Wolfe ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 10 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	2	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) John J. Wojciechowski 112 S. Wolfe Street

15 Filed JUL 16 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1923

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1923, to July 15, 1923

that I last saw her alive on July 15, 1923

and that death occurred, on the date stated above, at 8.10 p m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 4 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Leo. Keller M. D.

7/16/23, 19 (Address) 193 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL July 17 1923

20 UNDERTAKER John. M. Weber — ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE MUST BE FILLED OUT COMPLETELY. AGE should be stated EXACTLY. PHYSICIAN should be carefully supplied. OCCUPATION should be properly classified. Exact statement of OCCUPATION may be plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates. TION is very important.

Spec.—1-10-21 M&T 1500 Blks.

Graves; R B Glenn. 44 Lake Gardens

D77564

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77564

REGISTERED NO.

1. PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 E. Lanvale ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2. FULL NAME James R. Graves

(a) RESIDENCE NO. 1205 E Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen E. Walker.

6 DATE OF BIRTH (month, day, and year) Oct. 30, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72.	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer) Contractor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Geo. Graves

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Love

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Ellen E Graves (Address) 1205 E Lanvale.

15 JUL 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1923

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1923, to July 14, 1923, that I last saw him alive on July 11, 1923, and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows: Cancer Stomach 7 mos

(duration) 10 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) R O Eckelmann M. D.

July 16, 1923 (Address) Parkeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL 7/17 1923

ADDRESS

20 UNDERTAKER E J Bunting & Son 938 E Lafayette ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE must be filled out EXACTLY. Information required in every item. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. So that it may be plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificate. CAUSE OF DEATH is very important. See Instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

D77555

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 16-002 D77555

CERTIFICATE OF DEATH

1-PLACE OF DEATH Nursery and Childs Hospital

CITY OF BALTIMORE: (No. Franklin and Schroeder STS. 18 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Fore

(a) RESIDENCE NO..... ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	1	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) New York city
(State or country) N.Y.

PARENTS

10 NAME OF FATHER Ernest Fore.

11 BIRTHPLACE OF FATHER (city or town).....
(State or country) unknown.

12 MAIDEN NAME OF MOTHER Lida Lowery

13 BIRTHPLACE OF MOTHER (city or town).....
(State or country) unknown

14 Informant.....
(Address)

15 JUL 16 1923 ROBERT R. KRAUTER
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1923

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1923, to July 14, 1923, that I last saw him alive on July 13, 1923, and that death occurred, on the date stated above, at 1:30 AM m.

The CAUSE OF DEATH* was as follows:

Dysentery (bacillary)

(duration) yrs. mos 4 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lawson Wilkins M. D.

July 14 1923 (Address) 1014 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JUL 16 1923

THE MORGUE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK must be filled EXACTLY. PHYSICIANS mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D77556

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90. D77556

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1144 E North Ave ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard E Davidson

(a) RESIDENCE. No. 1144 E. North Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

If married, widowed or divorced HUSBAND of (or) WIFE of: Mary E Davidson

6 DATE OF BIRTH (month, day, and year): Oct 15 1858

7 AGE: Years 66 Months 8 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Collector

(b) General nature of industry, business, or establishment in which employed (or employer): Blum Clothing

(c) Name of employer: Dept

9 BIRTHPLACE (city or town) (State or country): England.

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): England.

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England.

14 Informant (Address): Mary E Davidson 1144 E North Ave.

15 [illegible] 19 Registrar.

JUL 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 13 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9 1923 to July 13 1923.

that I last saw him alive on July 13 1923.

and that death occurred, on the date stated above, at 5.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Stomach

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heal exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M.D.

, 19 (Address) 1167 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: July 17 1923

20 UNDERTAKER: E A Weedfield — ADDRESS: 501 E 22 St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE MUST BE FILLED OUT EXACTLY. PHYSICIAN'S AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may not be misunderstood. See instructions on back of certificates. See instructions on back of certificates. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D77557

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D77557

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 E. Fremont St. 21 WARD)

2-FULL NAME Ruth V. Garrison

(a) RESIDENCE NO. 604 E. Fremont St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 4 22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		7	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work 2 8
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Furman Garrison

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Lina Rothgeb

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Laura Garrison
(Address) 604 E. Fremont

15 Filed JUL 16 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ... (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Heat & food.

(duration) ... yrs. ... mos. ... ds.

(Signed) H K Long, M. D.
(Coroner.)

July 16, 1923 (Address) 111 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: July 17 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E Pratt

N. B.—WRITE PLAINLY. Ink should be used. AGE should be carefully supplied. Exact statements of facts are required, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of facts are required, so that it may be properly classified. AGE should be carefully supplied

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77558

CERTIFICATE OF DEATH.

47 D77558

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2113 Eutaw Pl. ST., 15 WARD)

2-FULL NAME Annie Sachs

(a) RESIDENCE NO. 2113 Eutaw Pl ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 10 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Henry Sachs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Esther Sachs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant, Henry Sachs (Address) 1519 Richmond St

15 FILED JUL 16 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1923

17 I HEREBY CERTIFY, That I attended deceased from for 12 to 18 months last . 19 . that I last saw her alive on July 15th . 1923, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows: Cancer of right breast. Duration 2 or 3 yrs. ago. Recurring, also appearing in right knee. Pleural cavity eaten into.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? As stated above.

Was there an autopsy? No.

What test confirmed diagnosis? X

(Signed) O. H. Hoffman M. D.

7/16. 1923 (Address) 3402 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 17 1923

20 UNDERTAKER	ADDRESS
Wm. Cook	562 E. Lan

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS ... mation should be carefully supplied. AGE should be ... CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See Instructions on back of ... should be stated EXACTLY. ... y be properly classified. Exact statement of OCCUPA- ... k of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77559 — 31 — D77559

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 739 McCabe Ave ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna T. Clark

(a) RESIDENCE NO. 739 McCabe Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward C Clark

6 DATE OF BIRTH (month, day, and year) May 20 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Thomas W Trenchard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ella Pettitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant G. P. Pettitt Trenchard

(Address) 3221 Abell Ave

15 JUL 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1923

17 I HEREBY CERTIFY, That I attended deceased from March, 1922, to July 15, 1923, that I last saw him alive on July 13, 1923, and that death occurred, on the date stated above, at 8-30 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(duration) 2 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Pneumonia 2 ago. (duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No Symptoms -

What test confirmed diagnosis?

(Signed) Jos Carpenter, M. D.

7/16 1923 (Address) 2303 N Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL July 17 1923

20 UNDERTAKER Wm Cook 502 E N Ave — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—ALL information should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

77560 D77560

REGISTERED NO. 90 D77560

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Mount Hope Retreat ST. 26th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Irwin -

(a) RESIDENCE. NO. Mt Hope Retreat ST. 26th WARD. Woodstock - Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 10 mos. 0 ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Mrs Irwin

6 DATE OF BIRTH (month, day, and year) About 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	60	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Woodstock Va

PARENTS

10 NAME OF FATHER Patrick Reilly

11 BIRTHPLACE OF FATHER (city or town) Co. Clare (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret O'connor

13 BIRTHPLACE OF MOTHER (city or town) Co Clare (State or country) Ireland

14 Informant Records of Mt Hope Retreat (Address) Mt Hope Md.

15 Filed JUL 17 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 20 1920, to July 13 1923.

that I last saw h Er alive on July 14 1923.

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

Complicated by Val. (mitral) Dis. of Heart

abt (duration) 0 yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis.

abt (duration) 3 or 4 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Richmond Va. -

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

July 13, 1923 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodstock Va — DATE OF BURIAL July 17 1923

20 UNDERTAKER STEWART & MOWEN COMPANY (Stewart Mowen Sr.) ADDRESS 100 W. LEXINGTON AVE.

N. B.—WRITE PLAINLY. WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be carefully supplied

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43

D77561

REGISTERED NO. D77561

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2134 Collington Ave ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Michael Glaser

(a) RESIDENCE NO. Same ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hettie Glaser

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): Clothes

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Joseph Glaser

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Theresa Hirshberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Hettie Glaser 2134 Collington ave

15 JUL 17 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 16th 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 29, 1922, to July 16th 1923, that I last saw h alive on July 11th 1923, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cheek

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary): Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Guy L. Broomwell M. D.

July 17 1923 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oheb Sholom Cem — DATE OF BURIAL 7/17 1923

20 UNDERTAKER: J. Ahrens Co — ADDRESS 1611 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION may be properly classified, so that it may be plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77562

CERTIFICATE OF DEATH.

D77562

74-001

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Hospital. ST., 76 WARD)

2-FULL NAME Sarah McGlone Hamill

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	68	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 10

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

Informant Mrs. David Carlson

(Address) 714 N. Stough St

15 JUL 17 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1923

17 I HEREBY CERTIFY, That I attended deceased from August 26, 1916, to July 14, 1923, that I last saw her alive on July 14, 1923, and that death occurred, on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Arteriosclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Goodwin M. D.

7-16 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem.

DATE OF BURIAL July 17 1923

ADDRESS

20 UNDERTAKER John Ullrich. 2008 Orleans St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Titus

Spec. 6-9-19—H. P. Co.—1000 Bks.

D77563

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77563

CERTIFICATE OF DEATH.

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1374 n. Stricker St. ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hanna Titus

(a) RESIDENCE. NO. 1374 n. Stricker st ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11-23-1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles W. Titus

11 BIRTHPLACE OF FATHER (city or town) Calvert Co.,
(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Holland

13 BIRTHPLACE OF MOTHER (city or town) Calvert Co.,
(State or country) Md.

14 Informant Charles W. Titus
(Address) 1374 n. Stricker St

15 Filed JUL 17 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-15- 1923

17 I HEREBY CERTIFY, That I attended deceased from 3-25- , 1923, to 7-15- , 1923.

that I last saw her alive on 7-13- , 1923.

and that death occurred, on the date stated above, at 12:55 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George C. Page M. D.

, 19 (Address) 1750 n. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. mutual Calvert Co

DATE OF BURIAL Jul 19 1923

20 UNDERTAKER Edward Bryan

ADDRESS 1631 [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION may be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77564 ✓ D77564

REGISTERED NO.

D77564

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hospital ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Pearre.

(a) RESIDENCE NO. Union Memorial Hosp ST., 14 WARD Cumberland, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? 68 yrs. 2 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) July 8, 1855.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	0	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance + Real Estate Agent.

(b) General nature of industry, business, or establishment in which employed (or employer) alone

(c) Name of employer alone ?

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER George a. Pearre.

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Worthington ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Hospital Records. (Address) Baltimore

15 JUL 17 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1923, to July 17, 1923.

that I last saw him alive on July 17, 1923,

and that death occurred, on the date stated above, at 3.33 Am.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Bladder.

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Cumberland, Md.

Did an operation precede death? Yes Date of July 12, 1923.

Was there an autopsy? No.

What test confirmed diagnosis? Cystoscopy.

(Signed) [illegible] M. D.

, 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cumberland Md. DATE OF BURIAL July 17 1923

20 UNDERTAKER STEWART & BOWEN COMPANY (WILLIAM F. [illegible], Supervisor) ADDRESS 1[illegible] W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of information should be carefully supplied

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77565

CERTIFICATE OF DEATH.

D77565

REGISTERED NO. 98

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1308 N Caroline ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Simonds

(a) RESIDENCE NO. 1308 N Caroline ST., 9 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? 70 yrs. 4 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Curtis B Simonds

6 DATE OF BIRTH (month, day, and year) March-25-1853

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
70	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Philip Ohlgart

11 BIRTHPLACE OF FATHER (city or town) ....
(State or country) Germany

12 MAIDEN NAME OF MOTHER ????? Sauter

13 BIRTHPLACE OF MOTHER (city or town) ....
(State or country) Germany

14 Informant Miss Anna A Simonds (daughter)
(Address) 1308 N Caroline St

15 Filed JUL 17 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1923

17 I HEREBY CERTIFY, That I attended deceased from July 5 1923 to July 16 1923
that I last saw h alive on July 16 1923
and that death occurred, on the date stated above, at 1a m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 30 yrs. mos ds.

CONTRIBUTORY (Secondary) Failure of Compensation
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical

(Signed) Wade L Simonds M. D.

July 16 1923 (Address) 1308 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: July-18-23

20 UNDERTAKER: STEWART & MOWEN COMPANY — ADDRESS: 108 W Mad[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77566

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77566

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2608 Maryland Ave ST., 12 WARD)

2-FULL NAME Annie Elizabeth Duke

(a) RESIDENCE NO. 2608 Maryland Ave ST., 12 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 89 yrs. 2 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George D Duke

6 DATE OF BIRTH (month, day, and year) May-8-1834

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) St Marys County Md.

PARENTS

10 NAME OF FATHER Thomas Hebb

11 BIRTHPLACE OF FATHER (city or town) St Marys Co (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Wise

13 BIRTHPLACE OF MOTHER (city or town) St Marys Co (State or country) Md

14 Informant Miss Katherine Duke (daughter)
(Address) 2608 Maryland Ave

15 Filed JUL 17 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1923

17

I HEREBY CERTIFY, That I attended deceased ~~from~~ for many years to July 16, 1923.

that I last saw her alive on July 15, 1923.

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Mitral)

(duration) Seven mos. 7 days

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry Oa. Bagley M. D.

, 19 (Address) 2605 W. Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Millstone St Marys County — DATE OF BURIAL: July 17/23

20 UNDERTAKER [illegible] — ADDRESS [illegible] NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

S·A·F·E·T·Y

D77567

HEALTH DEPARTMENT--CITY OF BALTIMORE

Reely

CERTIFICATE OF DEATH

74-82

D77567

REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 401 Whitridge ave ST. 12 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Clarence Reely.

(Residence in Baltimore: No. 401 Whitridge ave St.: 4 yrs. 2 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6 DATE OF BIRTH February 16, 1868 (Month) (Day) (Year)

7 AGE 55 yrs. 6 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Painter 50
(b) General nature of industry, business, or establishment in which employed (or employer) House Painting

9 BIRTHPLACE (State or country) Montgomery County

PARENTS

10 NAME OF FATHER Chas W. Reely.

11 BIRTHPLACE OF FATHER (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Henrietta Nicholson

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lillian M. Stein.

(Address) 401 Whitridge Ave

15 Filed JUL 17 1923 ROBERT R. KRANTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 14, 1923 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1923, to July 14 1923 that I saw h— alive on July 14, 1923, and that death occurred, on the date stated above, at 7.30 P m. The CAUSE OF DEATH* was as follows:

Paralysis.

(Duration) yrs. mos. 1 ds

Contributory (SECONDARY) (Duration) yrs. mos. ds.

(Signed) H. Shuckhardt M. D.

July 16, 1923 (Address) 632 Gorsuch ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death 4 yrs. 2 mos. 1 ds. In the State of Maryland 55 yrs. 6 mos. 28 ds.

Where was disease contracted, if not at place of death? At place of death.

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Parkwood Cemetery | DATE OF BURIAL July 17, 1923

20 UNDERTAKER David J. Wilfke | ADDRESS 153 W Fayette

N.B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

COPY

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77568

D77568

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. #97 St., Kelly Place WARD 13)

2-FULL NAME Hazel M. Patterson

(a) RESIDENCE NO. 97 Kelly Place ST.: WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 10 mos. 8 ds. How long in U. S., If of foreign birth? 0 yrs. 10 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 8/1922.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	0	10	8.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto city Md.

PARENTS
10 NAME OF FATHER Frank Patterson
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto city Md.
12 MAIDEN NAME OF MOTHER Mary E Shaffer
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary E. Patterson
(Address) 97 Kelly Place.

15 Filed JUL 17 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1923.

17 I HEREBY CERTIFY, That I attended deceased from 7-14 1923, to 7-16 1923.
that I last saw h[illegible] alive on 7-16 1923,
and that death occurred, on the date stated above, at 740 P. m.
The CAUSE OF DEATH* was as follows:

measles

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Duration

(duration) yrs. mos 10 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? (Found upon) P. Faughan
(Signed) M. D.
7/16 1923 (Address) 3704 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Marys Hampden. DATE OF BURIAL 7/17/1923

20 UNDERTAKER Walter Davis ADDRESS 330 Paine St

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of DECEASED'S age should be carefully supplied. AGE should be properly classified. it may be properly classified, so that it may be tabulated. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. on back of certificates. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77569

CERTIFICATE OF DEATH.

16 D77569

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Reid

(a) RESIDENCE NO. 320 E. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 9-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Off

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Johns Hopkins Hospital.
(State or country)

PARENTS

10 NAME OF FATHER Howard Reid

11 BIRTHPLACE OF FATHER (city or town) Philadelphia
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Josephine Clark

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia
(State or country) Pa.

14 Informant W.W. Gray

(Address) Johns Hopkins Hospital.

15 Filed JUL 17 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1923, to July 11, 1923, that I last saw h i Malive on July 11, 1923, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Atelectasis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) W.W. Gray, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

20 UNDERTAKER Commissioner Health. Address JUL 17 19

JOHNS HOPKINS HOSPITAL

Special Permit Clerk.

N. B.—WRITE PLAINLY, WITH INDELIBLE INK. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77570

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

D77570

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Dowell

(a) RESIDENCE NO. 1628 Jackson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

~~Johns Hopkins Hospital.~~

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 12-23

7 AGE	Years	Months	Days	If LESS than 1 day, 5 hrs. or 30 min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Johns Hopkins Hospital.
(State or country)

PARENTS

10 NAME OF FATHER Booth Dowell

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Bessie Weber

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant W W Gray
(Address) Johns Hopkins Hospital

15 Filed JUL 17 1923 19 ROBERT R. KRAUTER, Registrar
Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1923, to July 12, 1923, that I last saw her alive on July 12, 1923, and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) W W Gray, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Johns Hopkins Hospital.

DATE OF BURIAL JUL 17 1923 19

ADDRESS .....

20 UNDERTAKER Commissioner Health,

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of occupation should be carefully supplied. AGE should be carefully supplied, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

no. no H.L.A. D77574

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 M.

161 D77571

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 18 WARD)

2-FULL NAME Baby Bowers

(a) RESIDENCE NO. 837 Hollins St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. unknown. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 6, 1923.

7 AGE — Years: — Months: — Days: 6 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: Hazel Bowers.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUL 17 1923, 19..... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1923, to July 12, 1923, that I last saw her alive on July 12, 1923, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) 1 Life yrs. mos ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) A. A. Veech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19 JUL 17 1923

20 UNDERTAKER: Commissioner Health

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated IN FIGURES. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77572

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77572

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Marshall Court ST. 25 WARD) at Patapsco Ave Brooklyn

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madaline J. Thomas

(a) RESIDENCE NO. Marshall Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 1 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Richard E. Thomas

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Pearl J. Talbert

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Richard E. Thomas
(Address) Marshall Court

15 JUL 17 1923

ROBERT N. KRAUTH
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1923

17 I HEREBY CERTIFY, That I attended deceased from July 10. 1923 to July 17 1923

that I last saw h alive on July 16. 1923

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. E. Campbell M. D.

7 1923 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL 7/18/23

20 UNDERTAKER J. Fahey Sons

ADDRESS 1318 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY in every case. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77573 D77573

CERTIFICATE OF DEATH.

REGISTERED NO. 131

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sarah Adler

(a) RESIDENCE. NO. New Bern N. Car. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo Adler

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Solomon Coplan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bertha Yerell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Levis 1439 E Balto St

15 Filed JUL 17 1923 ROBERT R. KRAUTER, Registrar; Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1923

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1923, to July 16, 1923

that I last saw her alive on July 16, 1923

and that death occurred, on the date stated above, at 5.45 P.m.

The CAUSE OF DEATH* was as follows:

Shock

(duration) yrs. mos. 5 hrs

CONTRIBUTORY (Secondary) Pyonephroses

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Laparotomy 7/16/23

Was there an autopsy? No Operation

What test confirmed diagnosis?

(Signed) S. Adler, Landheimer, M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem. DATE OF BURIAL: July 17 1923

20 UNDERTAKER ADDRESS Jack Levis 1439 E Balto St

N. B.—WRITE PLAINLY, WITH ... mation should be carefully supplied. AGE should ... CAUSE OF DEATH in plain terms, so that it may ... TION is very important. See instructions on back ... should be stated EXACTLY. Exact statement of occupa... may be properly classified. ... of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

Spec.—1-10-21—M&T—1500 Blks.

D77574

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D77574

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2005 Bank St. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Jane Boyd

(a) RESIDENCE NO. 2005 Bank St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 12, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	64	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. City
(State or country) Md.

PARENTS

10 NAME OF FATHER James D. Boyd

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Elizabeth J. Boyd

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Scotland

14 Informant James Boyd
(Address) 2005 Bank St.

15 FILED JUL 17 1923 ROBERT K. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. , 1920, to July 16, 1923,

that I last saw her alive on July 16, 1923

and that death occurred, on the date stated above, at 12 40 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Valvular Dis Heart

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas. D. Kerr, M. D.

7/16/1923 (Address) 408 S Patterson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cemetery — DATE OF BURIAL: July 18, 1923

20 UNDERTAKER: Wm. C. Black, — ADDRESS: 927 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. ATION is very important.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77575

CERTIFICATE OF DEATH.

D77575

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 821 Boyd st ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kate Staten

(a) RESIDENCE No. 821 Boyd st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress 041
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) md.
(State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) Dont Know
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant Ada Schneider
(Address)

15 Filed JUL 17 1923 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. a few mos. ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. mos. ds.

(Signed) H B Bonsal M. D.
(Coroner.)

7-16 1923 (Address) 117 W Saratoga st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Hope Cemetery	July 17 1923
20 UNDERTAKER	ADDRESS
Thos Scott Hook	1216 W Pratt st

Information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D77576

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D77576

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hos ST., 9 WARD)

2-FULL NAME Zachariah Gray

(a) RESIDENCE NO. 1521 Aisquith St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary R. Gray

6 DATE OF BIRTH (month, day, and year): 12 | 26 | 1846

7 AGE: Years 76 Months Days If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Anarundel Co Md

PARENTS

10 NAME OF FATHER: Robert Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country): A A Co Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary R. Gray

(Address): 1521 Aisquith St

15 Filed JUL 17 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 14 1923

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1923, to July 14, 1923.

That I last saw him alive on July 14, 1923

and that death occurred, on the date stated above, at 5.45 A. m

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Intestinal obstruction.

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of July 12, 1923

Was there an autopsy? No. Clinically.

What test confirmed diagnosis?

(Signed) James H. Wilkerson M. D.

(Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery

DATE OF BURIAL: 7 | 18 | 1923

20 UNDERTAKER: George J. Ruth

ADDRESS: 1730 Harford

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY in every case. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. INFORMATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

Hand.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 ✓ D77577

D77577 REGISTERED NO.

1-PLACE OF DEATH. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. St. Joseph's Hospital WARD)

2-FULL NAME Mr. William Hand.

(a) RESIDENCE NO. 1100 E. Chase St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Hand.

6 DATE OF BIRTH (month, day, and year) 3/12/1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER James Hand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Elizabeth Hand (Address) 1100 E. Chase St

15 JUL 17 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/15/23

17 I HEREBY CERTIFY, That I attended deceased from July 13. 1923 to July 15. 1923.

that I last saw him alive on July 14. 1923,

and that death occurred, on the date stated above, at 6:00 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 2 mos — ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 1 yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? P.E. Symptoms, Ol. Urea,

(Signed) J. A. Ohmedieh, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem DATE OF BURIAL 7/18 1923

20 UNDERTAKER George J. Ruth ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified

Coppolino

D77578

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77578

CERTIFICATE OF DEATH.

5 179

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 267 1/2 N. Eden St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Charles Coppolino

(Residence in Baltimore: No. 267 1/2 N. Eden St.; yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	W-	S

6-DATE OF BIRTH. 12 (Month) | 17 (Day) | 1921 (Year)

7-AGE. 1 yrs. 8 mos. ds. If LESS than 1 day, ...hrs. or.... min.?

8-DICTATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE. (State or Country) Md

PARENTS

10-NAME OF FATHER. Paul Coppolino

11-BIRTHPLACE OF FATHER. (State or Country) Italy

12-MAIDEN NAME OF MOTHER. D. Coppolino

13-BIRTHPLACE OF MOTHER. (State or Country) Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. Coppolino

(Address) 267 N. Eden St.

15. JUL 17 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 17 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns. 1st 25% 2nd & 3rd

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner)

(Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents). At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer Cem. DATE OF BURIAL. July 18 1923

20-UNDERTAKER. George J. Ruth ADDRESS 1735 Hanford Av.

N. B.—Every item of information should be carefully supplied. Accuracy is important. Exact statement of cause must be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate. is very important.

Cor.—1-12-23—M&T—100 Blks.

D77579 HEALTH DEPARTMENT—CITY OF BALTIMORE

74-09 D77579

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 937 Pierce ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Cole

(a) RESIDENCE NO. 937 Pierce ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 6 1879

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
44		8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) Private
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Jacob Jamison

11 BIRTHPLACE OF FATHER (city or town) Balto City
(State or country)

12 MAIDEN NAME OF MOTHER Matilda Jamison

13 BIRTHPLACE OF MOTHER (city or town) Balto City
(State or country)

14 Informant Emma More
(Address) 937 Pierce Street

15 Filed JUL 17 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy, or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
(duration) Ten minutes yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion
(duration) yrs. mos. ds.

(Signed) H K Forsyth, M. D.
(Coroner.)
7-17, 1923 (Address) 111 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL July 17 1923

20 UNDERTAKER Mrs R. E. Elliott — ADDRESS 1752 Eastern Ave

N. B.—WRITE PLAINLY. All items must be carefully supplied. Age, color, and place of birth are important statistics and should be properly classified. Place of birth should be stated definitely, so that it may be properly classified. Place of birth should be stated definitely, so that it may be properly classified. Age, color, and place of birth are important statistics and should

Spec.—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77580

CERTIFICATE OF DEATH.

4 100-001 D77580

4-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital, St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward T. Robey

(a) Residence No. 48 Harrison St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1861

7-AGE.	If LESS than 1 day.
61 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Washington, D.C.

PARENTS.

10-NAME OF FATHER. Edward Robey

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Washington, D.C.

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Washington D

14- (Informant) Municipal Hospital Records

(Address)

15- Filed JUL 17 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

0555

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 13, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 13 19 23 to July 13 19 23

that I last saw h. in alive on July 13 19 23

and that death occurred, on the date stated above, at 7:40 P.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (Terminal) (Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. J. Goldsmith M.D.

7-14- 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
	19
20-UNDERTAKER. Commissioner Health.	ADDRESS JUL 17

Per Wm. E. WOODALL

N. B.—WRITE PLAINLY. All information required should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Exact statement of OCCUPATION required.

UNIVERSITY OF MARYLAND

Spec.—1-10-21—M&T—1500 Bks.

Geelhaar

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77554

D77581 CERTIFICATE OF DEATH. 25 161-00 D77581

D77554 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 Paloma ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Geelhaar

(a) RESIDENCE NO. 536 Paloma ST. Brooklyn Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 14/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Brooklyn Md (State or country)

PARENTS

10 NAME OF FATHER Fred L. Geelhaar

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Margaret A. Bradley

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mary Margt. Geelhaar (Address) 536 Paloma St.

15 JUL 17 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1923

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1923, to July 15, 1923, that I last saw h— alive on July 14, 1923, and that death occurred, on the date stated above, at 12- P m

The CAUSE OF DEATH* was as follows:

Pneumonia Bronch

(duration) yrs. mos ds.

CONTRIBUTORY —

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas F Brooks M. D.

, 19 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	7-17 19 23

20 UNDERTAKER E H B Hale ADDRESS 1156 W Pratt St

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77582

CERTIFICATE OF DEATH.

162 D77582

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 833 E. Eager ST., 10 WARD)

2-FULL NAME Baby Kelly

(a) RESIDENCE NO. 833 E. Eager ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 40 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Baby

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) July 17, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	0	40 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Michael J Kelly

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Marcella Donelly

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant
(Address)

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1923

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1923, to July 17, 1923
that I last saw her alive on July 17, 1923
and that death occurred, on the date stated above, at 10 80 a m.

The CAUSE OF DEATH* was as follows:

Atelectasis of Lung

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W W Gray M. D.

1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL July 1923

20 UNDERTAKER Henry Hoeck Son ADDRESS 1301 E Eager St

JUL 17 1923

B.—WRITE PLAINLY, WITH UNFAILING. AGE should be stated in every case. Exact information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Certificate should be signed and dated as soon as it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D77583

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77583

CERTIFICATE OF DEATH

1-PLACE OF DEATH Church Home and Inf

CITY OF BALTIMORE: (No. 6 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard C. Haines

(a) RESIDENCE NO. Woodbine Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 23-1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md.

PARENTS

10 NAME OF FATHER Elijah P. Haines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co Md.

12 MAIDEN NAME OF MOTHER Lucia Haines

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs C. H. Spindler

(Address) Woodbine

15 Filed JUL 17 1923, 19 Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1923

17

I HEREBY CERTIFY, That I attended deceased from June 17/23, 1923, to July 16, 1923,

that I last saw him alive on July 16, 1923

and that death occurred, on the date stated above, at 9 01 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of June 20 1923

Was there an autopsy? yes

What test confirmed diagnosis? Operation Autopsy

(Signed) Caystano Cauthorn, M. D.

, 19 (Address) Church Home and Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Howard Co Md Jennings Chapel

DATE OF BURIAL July 19 1923

20 UNDERTAKER Geo. J. Smith

ADDRESS 1552 Hollins St

N.B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. AGE should be carefully supplied. mation should be TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77584 ✓ D77584

D77584

CERTIFICATE OF DEATH.

92

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1819 Mc Henry. ST., 19 WARD)

2-FULL NAME Emil Kuhlew

(a) RESIDENCE NO. 1819 Mc Henry. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13. yrs. mos. ds. How long in U. S., if of foreign birth? 47. yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kuhlew

6 DATE OF BIRTH (month, day, and year) May 12-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	58.	2	2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cork Binder.

(b) General nature of industry, business, or establishment in which employed (or employer) Jas Field & Co

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER William Kuhlew.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Mary Kuhlew
(Address) 1819 Mc Henry St.

15 Filed ..... 19 ..... Robert P. Harrison, Registrar

JUL 17 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1923

17 I HEREBY CERTIFY, That I attended deceased from July 15. 1923. to July 16. 1923. that I last saw h[illegible] alive on July 16. 1923. and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Coronary Embolism.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema. (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar E. Pearce. M. D.

, 19 (Address) 1520 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL July 18. 1923

20 UNDERTAKER C. W. Dill — ADDRESS 307 Fallsway

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. AGE,

Cor.—1-12-23—M&T—100 Bks.

D77585

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77585

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital. ST., 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James H. Groener.

(a) RESIDENCE NO 1118 S. Paca St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. 2 mos. 21 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ — Grace Groener.

6 DATE OF BIRTH (month, day, and year) April 24, 1895.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	2	21.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stillman. 086
(b) General nature of industry, business, or establishment in which employed (or employer) Interocean Oil Co.
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Groener.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Elizabeth Neubert.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Grace Groener. (wife). (Address) 1118 S. Paca St.

15 Filed JUL 17 1923 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 1928.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the Spine.
Accidental fall from an oil tank.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto M. Reinhardt M. D.
(Coroner.)

July 17, 1928 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.
Where was disease contracted, if not at place of death? Accident
Inter Ocean Oil Co. Wagner's Point.
Former or usual residence July 15, 1928.

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL July 18 192

20 UNDERTAKER John J Cowan Son ADDRESS 901 Hollins St

mation should be furnished. CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77586

CERTIFICATE OF DEATH.

49 D77586

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 E Lafayette ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa D Beard

(Residence in Baltimore: No. 229 E Lafayette St.; 25 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, Feb 15 1841
(Month) (Day) (Year)

7-AGE, 82 yrs. 6 mos. 9 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): None

9-BIRTHPLACE, (State or Country). Pocomoke City Md

PARENTS.

10-NAME OF FATHER. J Mezick

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Laura Burgess

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs A C Beard

(Address) 229 E Lafayette

15-

Filed ....., 191.... Robert P. Harrison, Registrar.

JUL 17 1923 Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. Each statement CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 16, 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 6th 1923, to July 16th 1923, that I saw h[er] alive on July 15 1923, and that death occurred, on the date stated above, at 730 m.

The CAUSE OF DEATH* was as follows:

Cancer of Bladder

Carcinoma

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lemorrhages, Exhaustion

(Duration) yrs. mos. 20 ds.

(Signed) Joseph Eichelberger M. D.

July 17 1923 (Address) 1516 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Baltimore Cemetery	July 18, 1923.

20-UNDERTAKER Robt J Turner Inc ADDRESS 924 E Broadway

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77587

CERTIFICATE OF DEATH.

6 74-001 D77587

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 409 N. Deacon ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Harby

(a) RESIDENCE. NO. 409 N. Deacon ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Harby

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Matz Harby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Barbara Rohout

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Catherine Harby (Address) 409 N. Deacon

15 Filed JUL 17 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9 1923 to July 15 1923

that I last saw h— alive on July 14 1923

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William O'Connor M. D.

19 (Address) July 16 1923 807 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 18 1923

20 UNDERTAKER Geo. E. Crawford ADDRESS 1006 Carlton Ave

B.—WRITE PLAINLY. Words should be spelled out. AGE should be carefully supplied. Exact statement of mation should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D77588

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D77588

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1032 Enson ST., 10 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Allen

(a) RESIDENCE No. 1032 Enson ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James E. Allen

6 DATE OF BIRTH (month, day, and year) July 19-1838

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robert Boarman

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Wheeler

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Sadie M. Allen

(Address) 1032 Enson St

15 Filed JUL 17 1923, 19.....

Robert P. Harrison

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1923 to July 16 1923

that I last saw her alive on July 15 1923

and that death occurred, on the date stated above, at 7:50 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. S. Harding M. D.

7/16, 1923 (Address) 1216 N. Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Louis Long Green.	July 18 1923
20 UNDERTAKER	ADDRESS
Jd. C. Wedefeld	914 Gilmor Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77589

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D77589

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Colonial Hospital ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Crusey

(a) RESIDENCE NO. 1122 N. Mount St. ST. Colonial Hospital WARD City
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S.; if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): July 16-23

7 AGE — Years — Months — Days — If LESS than 1 day, 3 hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Colonial Hospital 1122 N. Mount St.

PARENTS

10 NAME OF FATHER Arthur Crusey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore City

12 MAIDEN NAME OF MOTHER Agnes Stork

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant A. Crusey
(Address) 1215 Walbrook Ave

15 Filed JUL 17 1923, 19

Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1923

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1923, to July 14, 1923, that I last saw him alive on July 16, 1923, and that death occurred, on the date stated above, at 9.30 m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(duration) yrs. 7 mos — ds.

CONTRIBUTORY (Secondary) Atelectasis (3 hrs.)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of July 16/23

Was there an autopsy? No

What test confirmed diagnosis? Inspection

(Signed) Wm. Grant, M. D.

, 19 (Address) 3043 W. Nunham

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL — DATE OF BURIAL

St Peters Cemetery July 23

20 UNDERTAKER — ADDRESS

Wm Cook 502 E North

N. B.—WRITE PLAINLY, WITH INK. All information should be carefully supplied. AGE should be stated. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CERTIFICATE is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D75903 9 — D77590

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Joseph Stevens

(a) RESIDENCE NO. ..... Alderson, W. Va.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Betty Stevens

6 DATE OF BIRTH (month, day, and year) Nov. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Joseph Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Bertha Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

Filed JUL 17 1923, 19 Robert F. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1923

17 I HEREBY CERTIFY, That I attended deceased from July 7th 1923, to July 17th 1923, that I last saw him alive on July 17th 1923, and that death occurred, on the date stated above, at 8 30 a.m.

The CAUSE OF DEATH* was as follows:

Lymphosarcoma of mediastinum

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not able to say

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) C. O. Weaver M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ALDERSON W. Va. DATE OF BURIAL July 17, 23

20 UNDERTAKER Jack Lewis ADDRESS 1439 E. Baltimore

NB.—WRITE PLAINLY, WITH INK. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

JUL 17 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77591

CERTIFICATE OF DEATH.

90 D77591

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 806 Westend ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexzander Jackson

(a) RESIDENCE NO. 806 Westend ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Color

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Napoleon Jackson.

6 DATE OF BIRTH (month, day, and year) FEB. 1857.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: HOUSE WIFE.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): ST. MARYS CO. Md.

PARENTS

10 NAME OF FATHER: DONT KNOW

11 BIRTHPLACE OF FATHER (city or town) (State or country): MD.

12 MAIDEN NAME OF MOTHER: DONT KNOW.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): MD.

14 Informant: NAPOLEON JACKSON.

(Address): 806. W. OSTEND. ST.

Filed 7 1923 19 Robert F. Bell

Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-15- 1923

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1923, to July 15, 1923, that I last saw her alive on July 15, 1923, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen Brain, M. D.

, 19 (Address) 1727 Mosher Alley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MT. AUBURN CEM.

DATE OF BURIAL: 7-18 1923

20 UNDERTAKER: David Easton

ADDRESS 96 Paine

N. B.—WRITE PLAINLY, WITH CARE. AGE should be stated ... mation should be carefully supplied. Exact statement of ... CAUSE OF DEATH in plain terms, so that it may be properly classified. ... TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

16492
D77592

HEALTH DEPARTMENT—CITY OF BALTIMORE

X46 D77592

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (NO. " " " ST., 7 WARD)

2-FULL NAME Mrs. Amanda Griffith.

(a) RESIDENCE NO. Gaithersburg, Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 days mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of E. Bartlett.

6 DATE OF BIRTH (month, day, and year) 2, 1881.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	42	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerical. 009

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Julian Griffith.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Virginia Harper.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) JOHNS HOPKINS HOSPITAL. Secondary

15 Filed July 17 1923 Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1923

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1923, to July 17, 1923, that I last saw h alive on July 17, 1923, and that death occurred, on the date stated above, at 3.25 P. m.

The CAUSE OF DEATH* was as follows:

Operation for removal of complete ileus
Postoperative paralytic ileus
(duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary) operation as given above
(duration) — yrs — mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of July 10 23

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) [illegible] M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gaithersville Md — DATE OF BURIAL July 17 1923

20 UNDERTAKER Das Ahrens — ADDRESS 221 Aisq

CAUSE: should be carefully supplied. AGE should be carefully classified. Exact statement of it may be properly classified, so that it may be in plain terms, so that it may be on back of certificates.
OF DEATH is very important. See instructions on b

Spec.—1-10-21—M&T—1500 Bks.

D77593

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D77593

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4708 Reisterstown Rd ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Shlom

(a) RESIDENCE NO. 4708 Reisterstown Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Shlom

6 DATE OF BIRTH (month, day, and year) March 14 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing

(c) Name of employer Merchant

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Meyer Shlom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hinton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Baltimore St

15 Filed July . 19 JUL 19 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1923

17 I HEREBY CERTIFY, That I attended deceased from June, 1922, to July 16, 1923, that I last saw h in alive on July 16 1923 and that death occurred, on the date stated above, at 10:05 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Hypertrophied Prostate

(duration) 1 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urinary Sediment

(Signed) Harry S Bick M. D.

July 17 1923 (Address) 305 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Friendship DATE OF BURIAL July 19 1923

20 UNDERTAKER Jack Lewis ADDRESS 1439 E. Balto

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77594

D77594

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2117 W Pratt St ST., 19 WARD)

2-FULL NAME Katherine T. Davis

(a) RESIDENCE NO. 2117 W Pratt St ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced, ~~HUSBAND~~ of (or) WIFE of Joseph Davis

6 DATE OF BIRTH (month, day, and year) Oct. 24-1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	26	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo. E. Ritter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Catherine Kramer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Joseph W. Davis (Address) 2117 W. Pratt St.

15 Filed M.P. JUL 18 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1923

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1923, to July 16, 1923.

that I last saw h[illegible] alive on July 16, 1923.

and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Convulsions

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Nephritis (duration) yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? ~ Date of

Was there an autopsy? —

What test confirmed diagnosis? ~

(Signed) W. O'Neill, M. D.

7/16, 1923 (Address) 1088 W Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. View Cathedral — DATE OF BURIAL July 19 1923

20 UNDERTAKER George L. Schwab — ADDRESS 1101 Eutaw St.

N. B.—WRITE PLAINLY, WITH CARE. AGE should be carefully supplied. Exact statement of DECEASED'S AGE should be stated. Information should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. TION is very important.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77595

CERTIFICATE OF DEATH.

44 D77595

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 617 N. Pulaski ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Larina Francis King

(a) RESIDENCE. NO. 617 N. Pulaski ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 5 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Francis King

6 DATE OF BIRTH (month, day, and year) Feb 5 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	5 mos	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Jacob Askler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary B. King
(Address) 617 N. Pulaski St.

15 Filed JUL 18 1923 19 Registrar ROBERT R. KRAUTER, Burial Permit Clerk.

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be properly classified. Exact statement of date of birth should be carefully supplied. AGE should be carefully supplied

Spec.—1-10-21 M&T 1500 Blks.

D77596

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77596

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Oak Place ST., Guilford 17 WARD)

2-FULL NAME Meta Oliver Fowler

(a) RESIDENCE NO. Oak Place ST., Guilford WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, ~~Widowed,~~ or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 14-1861

7 AGE: Years 62 Months 6 Days 3 If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Lady.
(b) General nature of industry, business, or establishment in which employed (or employer): at Home
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER de Grasse B. Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER Julia Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant (Address): Miss Fowler Oak Place Guilford

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

JUL 18 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1923

17 I HEREBY CERTIFY, That I attended deceased from July 14. 1923 to July 17. 1923
that I last saw her alive on July 17. 1923
and that death occurred, on the date stated above, at 10 00 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Arteriosclerosis arterio-hypertension

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No What test confirmed diagnosis? Physical diagnosis

(Signed) Wm B Mayo M. D.

19 (Address) Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Patterson N. J. DATE OF BURIAL 7/19 1923

20 UNDERTAKER: H. W. Jenkins Sons Co ADDRESS McCulloh Carlton

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. AGE should be carefully supplied, so that it may be properly classified. Exact statement of occupation should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77597 CERTIFICATE OF DEATH. 179 D77597

1-PLACE OF DEATH University Hospital REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST., 77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melvin Milbom

(a) RESIDENCE NO. 102 W. York ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY with pen and ink. AGE should be carefully supplied. Exact statement of occupation should be carefully supplied. AGE should be carefully supplied. Exact statement of occupation may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 60; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Henry Milbom

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Ellen Duffy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Anna Allen — (Address)

15 Filed JUL 18 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 11 1923.

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1923, to July 11, 1923.

That I last saw him alive on July 11, 1923, and that death occurred, on the date stated above, at 9:40 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with Hypertension

(duration) Unknown

CONTRIBUTORY (Secondary) Anemia (duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Signs.

(Signed) B. McK Rhodes, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

JUL 17 1923

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77598 CERTIFICATE OF DEATH. 1 1619006 D77598

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. 1 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret Shamer

(Residence in Baltimore: No. 507 S. Robinson St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	

6-DATE OF BIRTH. July 13/23 1.....
(Month) (Day) (Year)

7-AGE. 6 hrs. yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Bal to. Md.

PARENTS.

10-NAME OF FATHER. St.Clair Shamer

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Margaret Myers

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Johns Hopkins Hosp.

(Address).....

15- Filed JUL 18 1923, 19.. ROBERT R. KRAUTER, Burial Permit Clerk, Registrar.

0557

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 13/23 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held un.... inquiry ....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said..... (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S Dale M. D.
(Coroner.)

7/16 23 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. 19..

JOHNS HOPKINS HOSPITAL JUL 19 1923

20-UNDERTAKER. ADDRESS

N. B.—Every item of information should be carefully supplied. Exact statements state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77599

CERTIFICATE OF DEATH.

+ 44 D77599

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Sir John S. Hendrie

(a) RESIDENCE NO. Hamilton Ontario ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of Lady Lena Maude Hendrie

6 DATE OF BIRTH (month, day, and year) Aug 15th 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	69	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hamilton Ontario

PARENTS

10 NAME OF FATHER Wm Hendrie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Margaret Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1923

17 I HEREBY CERTIFY, That I attended deceased from July 7 1923, to July 17 1923, (that I last saw h[illegible] alive on July 11 1923, and that death occurred, on the date stated above, at 11-57 p.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia
following operation
for carcinoma of sigmoid

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Carcinoma of Sigmoid

(duration) yrs. 2 mos. da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 7-12-23

Was there an autopsy? 7-14-23

What test confirmed diagnosis? No

(Signed) F. L. Reichert M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hamilton Ontario	July 18 1923
20 UNDERTAKER Henry W. Gutsim & Sons Co	ADDRESS Whitelock & Orchard Sts.

N. B.—WRITE PLAINLY, WITH INK. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. MEDICAL CERTIFICATION is very important.

Spec.—1-10-21 M&T 1500 Bks.

D77600 HEALTH DEPARTMENT—CITY OF BALTIMORE D77600

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Holder Ave Lauraville ST., 27 WARD)

2-FULL NAME Henry Knecht

(a) RESIDENCE No. Holder Ave Lauraville ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Knecht

6 DATE OF BIRTH (month, day, and year) Oct. 9. 1859.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
63	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Knecht

(Address) Holder Ave Lauraville

15 Filed JUL 18 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16. 1923

17

I HEREBY CERTIFY, That I attended deceased from July 7, 1923, to July 16, 1923.

that I last saw h... alive on July 16, 1923.

and that death occurred, on the date stated above, at 9.35 P. m.

The CAUSE OF DEATH* was as follows:

Auricular Fibrillation

Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Intestitial Nephritis

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Claus Jensen, M. D.

7/17. 1923 (Address) 4 202 Harford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 19. 1923

20 UNDERTAKER ADDRESS

Mr. & Mrs. John W. Teufel & Son 801 W. Fayette St

N. B.—WRITE PLAINLY, WITH INK. AGE should be carefully supplied. Exact statement of deceased's age in years, months and days, as near as information should be carefully supplied. AGE should be carefully supplied. Exact statement of deceased's age in years, months and days, as near as it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77601

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

5 197

D77601 Registered No. C.....

City of BALTIMORE: (No. Mercy Hosp St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Edward Chestnut Jr.

(Residence in Baltimore: No. Mercy 1141 E Fair May St.; 18 yrs., 1 mos. ds.)

N. B.—Every item of information should be carefully supplied. Exact statement is required, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Col.	Single

6-DATE OF BIRTH. ..... 1.....
(Month) (Day) (Year)

7-AGE. 29 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION.
(a) Trade, profession, or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country) S. C.

PARENTS.

10-NAME OF FATHER. Dan. Chestnut

11-BIRTHPLACE OF FATHER. (State or Country) S. C.

12-MAIDEN NAME OF MOTHER. Eliza Mathews

13-BIRTHPLACE OF MOTHER. (State or Country) S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Bee Grant

(Address) 1141 May

15- Filed JUL 18 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH. July 14 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage duodenal ulcer
Chest wound, gunshot
(Duration) 4 hours yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(Duration) yrs. mos. ds.

(Signed) [signature] M. D.
(Coroner)

July 16 1923 (Address) 1639 Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents)
At place of death..... yrs. mos. ds. In the State 4 yrs. 5 mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Laurel Cemetery DATE OF BURIAL. July 18 1923

20-UNDERTAKER. Mrs. Chas. B. Jones ADDRESS 1225 Eutaw

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77602 ✓ D77602

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hos. ST. 15 WARD)

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris Leap

(a) RESIDENCE No 2407 Nelson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13		29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) School
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Simon Leap

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Esther Leap

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Simon Leap
(Address) 2407 Nelson St.

15 Filed JUL 18 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fatal Epilepsy
Probably

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Accidental Fall Injuries

(duration) yrs. mos. ds.

(Signed) C. T. Hamrick, M. D.
(Coroner.)

July 17, 1923 (Address) 2 E. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rozedale Cemetery	July 18 1923
20 UNDERTAKER A. Jenson Bro	ADDRESS 712 E. Baltimore St

mation should be given. CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D77603

D77603

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1244 Sharp St. ST., 73 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence A. Meyers

(a) RESIDENCE NO. 1244 Sharp St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna L. Meyers

6 DATE OF BIRTH (month, day, and year) Dec. 8" 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	32	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Crossing Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) B and O R. R. 073

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Meyers

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Rachel Meyers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. Anna L. Meyers

(Address) 1244 Sharp Street

15 Filed JUL 18 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15" 1923

17

I HEREBY CERTIFY, That I attended deceased from May 6 1923, to July 16-17 1923,

that I last saw h[illegible] alive on July 16-17 1923,

and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Interstitial Laryngitis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Senile Arter. Sclerosis

(duration) yrs. 1 mos ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Robt E. Schmidt, M. D.

7/16 1923 (Address) 1318 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Co	July 18 1923
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 W Balto St

N. B.—WRITE PLAINLY, WITH INK. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77604 ✓ 7 × 16 - 00 ✓ D77604

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gordon Geo. Gruppe

(Residence in Baltimore: No. Rossville, Md. St.; yrs.,.....mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	white	single

6-DATE OF BIRTH.

.....1.....
(Month) (Day) (Year)

7-AGE. 2 yrs. 4 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Wm. E. Grupp

11-BIRTHPLACE OF FATHER. (State or Country). Penna.

12-MAIDEN NAME OF MOTHER. Dora Krebs

13-BIRTHPLACE OF MOTHER. (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barara Schallin

(Address) York Pa.

15-

Filed JUL 18 1923 19..

Robert P. Harrison, Registrar.

Burial Permit Clerk.

N. B.—Every item of information should be carefully supplied. Exact statement is required, so that it may be properly classified. Exact statement of state CAUSE OF DEATH in plain terms, so that is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 16/23
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dysentery

(Autopsy at hospital)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. S. H. Gallner M. D.
(Coroner.)

7/17/23 (Address) 505 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Oakland Cemetery DATE OF BURIAL. July 21 1923

20-UNDERTAKER. Wm. Cook ADDRESS 502 E. North Ave

Spec.—1-10-21—M&T—1500 Blks.

Duncan 5106 York Road. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77605

CERTIFICATE OF DEATH.

44 D77605

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 4900 York Road ST., 27 WARD)

2-FULL NAME Capt. Thomas J. Hoffman's

(a) RESIDENCE NO. 4905 York Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence M. Hoffman

6 DATE OF BIRTH (month, day, and year) March 27 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Florence Hoffman (Address) 4900 York Road

15 Filed . . . . 19 . . . . Robert F. Harrison, Registrar

JUL 18 1923 Burial Permit Clerk

N. B.—WRITE PLAINLY with pen and ink. AGE should be carefully supplied. Exact statement of DISEASE or CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1923

17

I HEREBY CERTIFY, That I attended deceased from July 10, 1923, to July 17, 1923, that I last saw him alive on July 16, 1923, and that death occurred, on the date stated above, at 10-30 m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. M. Duncan, M. D.

7/17, 1923 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 19 1923
20 UNDERTAKER	ADDRESS
Wm. Cook & Son	

Spec.—1-10-21—M&T—1500 Bks.

D77606

HEALTH DEPARTMENT—CITY OF BALTIMORE

44 D77606

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Uffington Rd. Hill Top ~~Park~~ 37 WARD)

2-FULL NAME William Walter Pennington

(a) RESIDENCE NO. Uffington Rd. Hill Top Park WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Feb. 14 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Annapolis Junc. Md.

PARENTS

10 NAME OF FATHER Chas. P. Pennington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Caroline A. Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Jennie Pennington
(Address) Uffington Rd. Hill Top Park

15 Filed JL 18 1923 19..... Robert F. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1923

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1923, to July 16, 1923.
that I last saw him alive on July 16, 1923,
and that death occurred, on the date stated above, at 10.20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

About (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs.

(Signed) H. F. Stansbury, M. D.

7/18 1923 (Address) 714 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery DATE OF BURIAL July 17 1923

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

N.B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated in years, months and days. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Physicians are requested to report cases of death promptly to the Health Department. See Instructions on back of certificates. PROMPT REPORTING OF DEATH is very important.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77607

CERTIFICATE OF DEATH.

182 D77607

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Off Brooklyn. ST., 24 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William W. Carr.

(a) RESIDENCE NO 1450 Battery Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. 11 mos. 13 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Widower.

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 3, 1866.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	11	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Carr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Matilda Wilson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant George A. Carr, (brother). (Address) 2141 Walbrook Ave.

15 Filed JUL 18 1923 192 Registrar

Robert F. Merriken, Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16. 1923, 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Accidental fall from a boat.
..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt (Coroner), M. D.

July 17, 192 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL July 20 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

D77608

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77608

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2339 Eastern Ave ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stanislaus Jegulski

(a) RESIDENCE NO. 2339 Eastern Ave ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

Single

6 DATE OF BIRTH (month, day, and year) March 31-1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	22	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Apprentice 086

(b) General nature of industry, business, or establishment in which employed (or employer) Machine Shop

(c) Name of employer Castro

9 BIRTHPLACE (city or town) Balt

(State or country) Md

PARENTS

10 NAME OF FATHER Frank Jegulski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Jadwiga Jegulski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Jad. Jegulski

(Address) 2339 Eastern Ave.

15 [illegible] Robert P. Harrison, Registrar

OCT 18 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/15 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 7, 1923, to July 15, 1923, that I last saw h[illegible] alive on July 15, 1923 and that death occurred, on the date stated above, at 8.15 P m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic Interstitial

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Exophthalmus (Non Goitrous)

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Samuel Friedenwald, M. D.

19 (Address) 320 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary DATE OF BURIAL 9/19 1923

20 UNDERTAKER William Fallsworth ADDRESS 1145 Eut

B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of mation should be carefully supplied. AGE should be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

165047
D77609

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D77609

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hospital. (6 WARD)

CITY OF BALTIMORE: (NO. " " " ST.,

2-FULL NAME George Strickroth.

(a) RESIDENCE NO. 2225 Orleans St. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Theresa (mother).

6 DATE OF BIRTH (month, day, and year) Aug 27, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	10	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cahiel.

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Theresa Reid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria

14 Informant JOHNS HOPKINS HOSPITAL. Records
(Address)

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk

JL 18 1923

B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated correctly. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1923

17 I HEREBY CERTIFY, That I attended deceased from July 12 1923 to July 18 1923.

that I last saw him alive on July 18 1923.

and that death occurred, on the date stated above, at 8-20 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Kidney

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Miliary Tuberculosis

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL July 20 23

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77610

CERTIFICATE OF DEATH.

114 D77610

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2405 Eastern av ST., WARD)

2-FULL NAME John Michlowski

(a) RESIDENCE NO. 2405 Eastern av ST., WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	✓

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 6-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) 2405 Eastern Balto Md

PARENTS

10 NAME OF FATHER Georg Michlowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Teresa Michlowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Teo Michlowski

(Address) 2405 Eastern

15 Filed JUL 18 1923, 19.. Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1923

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1923, to July 18, 1923, that I last saw h.. alive on July 17, 1923, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Enteritis

(duration) .... yrs. mos 14 ds.

CONTRIBUTORY (Secondary) none

(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) O K Mays Jr M. D.

, 19 (Address) 2438 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL German Hill Road DATE OF BURIAL 7/20 1923

Holy Cross

20 UNDERTAKER Frederick W Ozoneck ADDRESS 1830 Eastern av

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY in every case. Exact statement of information should be carefully supplied. AGE should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77611

CERTIFICATE OF DEATH.

129 D77611

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 Lynd hurst St. or Ave. WARD)

2-FULL NAME Albert Isador Neefrich

(a) RESIDENCE NO. 519 Lynd hurst Ave WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Neefrich

6 DATE OF BIRTH (month, day, and year) 6-19-60

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
63	63		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer S. Eichelberger

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Kilibian

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Beltz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Daughter
(Address)

15 Filed JUL 18 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-16 1923

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1923, to July 16th, 1923, that I last saw him alive on July 16th, 1923, and that death occurred, on the date stated above, at 10 1/2 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Odema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Barron McCleary M. D.

7/16 1923 (Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem — DATE OF BURIAL 7/19 23

20 UNDERTAKER Geo A Farley Sucsr to Lafayette — ADDRESS

N. B.—WRITE PLAINLY, WITH INK. AGE should be carefully supplied. Exact statement of DATE OF DEATH and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of BIRTH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77612 ✓ 74-00 D77612

D77612

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 25 WARD)

2-FULL NAME Stephen Witkowski

(a) RESIDENCE NO. Brooklyn, Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
63				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Truck Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) — (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Witkowski

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Josephine Swift

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany.

14 Informant University Hospital Records (Address)

15 FILED JUL 18 1923, 19 Registrar Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1923

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1923, to July 18, 1923, that I last saw him alive on July 18, 1923, and that death occurred, on the date stated above, at 3.25 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage with right sided Hemiplegia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Pulmonary odema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Brooklyn Md.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) B. M. Rhodes, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 21 1923
20 UNDERTAKER	ADDRESS
John M. Weber	1803 Bank St

4 B.—WRITE PLAINLY with pen and ink. Fill all blanks. Data must be carefully supplied. AGE should be carefully supplied. Exact statement of date of birth may be properly classified. Exact statement of AGE in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77613 ✓ D77613

CERTIFICATE OF DEATH.

146

REGISTERED NO.....

1-PLACE OF DEATH

OF BALTIMORE: (No. 2938 Elliott ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Jasimchuk

(a) RESIDENCE. NO. 2938 Elliott ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Andrew

6 DATE OF BIRTH (month, day, and year) Feb 10 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Chas Jaskiewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Helen Mucha

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant (Address) Andrew Jasimchuk 2938 Elliot St

15 [illegible] Registrar

UL 18 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1923

17 I HEREBY CERTIFY, That I attended deceased from July 11 1923, to July 17 1923, that I last saw her alive on July 17 1923, and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Puerperal Septicaemia

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) D. B. Bromwhar, M. D.

7-18 1923 (Address) 3037 Channell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 20 1923

20 UNDERTAKER	ADDRESS
John M Weber	803 Bank St

N.B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates.

ALICE JONES

D77614

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77614

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1125 N. Calhoun St.; 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Jones St.; yrs. 10 mos. ds.)

(Residence in Baltimore: No. 1125 N. Calhoun St.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) single

6-DATE OF BIRTH, (Month) Sept. (Day) 11 (Year) 1912

7-AGE, yrs. 10 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work (Infant)
(b) General nature of industry, business, or establishment in which employed (or employer) Home

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Norman Jones

11-BIRTHPLACE OF FATHER, (State or Country). [illegible]

12-MAIDEN NAME OF MOTHER, Dorothy Brown

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Norman Jones

(Address) 1125 N. Calhoun

15- Filed JUL 19 1923 192.... ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, (Month) July (Day) 17 (Year) 192[illegible]

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an [illegible] (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said [illegible] (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebro-meningitis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

(Coroner)

192.... (Address) [illegible]

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents). At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, [illegible] DATE OF BURIAL, July 19 1923

20-UNDERTAKER, James A. Lewis ADDRESS 130-2 [illegible]

N. B.—Every item of information should be carefully supplied. Exact statements should be properly classified. Exact statements of fact may be given in plain terms, so that it may be properly classified. Exact statements of fact may be given in plain terms, so that it may be properly classified. Exact statements of fact may be given in plain terms, so that it may

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77615 — 161-001 — D77615

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hospital for Women of Maryland — REGISTERED NO.

CITY OF BALTIMORE: (No. John + Lafayette ST., 16 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hoffman

(a) RESIDENCE NO. 2644 Harlem Ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female — 4 COLOR OR RACE: White — 5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 17, 1923

7 AGE — Years — Months — Days — If LESS than 1 day, 0 hrs. or 34 min.
34 minutes

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Women's Hospital Baltimore, Md.

10 NAME OF FATHER Rubeman J. Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Thelma Fedrid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Rubeman J. Hoffman
(Address) 2644 Harlem ave - City

15 Filed JUL 19 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from 6 10 P.M. July 17, 1923, to 6 44 P.M. July 17, 1923, that I last saw her alive on July 17, 1923, and that death occurred, on the date stated above, at 6 44 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) J. Ogle Warfield, Jr., M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery — DATE OF BURIAL July 19, 1923

20 UNDERTAKER [redacted] — ADDRESS [redacted]

N. B.—WRITE PLAINLY, WITH INK. AGE should be carefully supplied. Exact statement of DECEASED'S mation should be carefully supplied. AGE should be properly classified. Exact statement of DECEASED'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DECEASED'S TION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77616

D77616

CERTIFICATE OF DEATH.

90 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2510 West Lanvale ave St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ann Kabernagel

(a) Residence No. 1636 East Pratt St., Ward.

(Usual place of abode) about (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George Kabernagel

6-DATE OF BIRTH (month, day and year) Don't Know

7-AGE. about 70 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, John A. Fiers

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Mrs Charles R. Krauter

(Address) 2510 West Lanvale ave

15- Filed JUL 19 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 17th 1923

17- I HEREBY CERTIFY, That I attended deceased from June 22, 1923 to July 17 1923.

that I last saw her alive on July 17 1923

and that death occurred, on the date stated above, at 630 m.

The CAUSE OF DEATH* was as follows:

Valvular Heart-Lesion

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hydrothorax

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) J. W. Wade M. D.

, 19 (Address) 468 Broadway

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery

DATE OF BURIAL. July 20, 1923

20-UNDERTAKER. Geo. Weber & Son

ADDRESS 2503 Edmondson

N. B.—WRITE carefully supplied. Ages should be carefully supplied. Exact statement of OCCUPATION should be

Spec.—1-10-21—M&T—1500 Bks.

D77617

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 D77617

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH 416 N Broadway

CITY OF BALTIMORE: (No. 416 N. Broadway ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Cenelia Virginia Cadwalader

(a) RESIDENCE NO. 416 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 7 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Arthur J. Cadwalader

6 DATE OF BIRTH (month, day, and year): Dec 16, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George K Manro

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Cornelia Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Arthur J. Cadwalader

(Address): 416 N Broadway

15 JUL 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 17 1923

17

I HEREBY CERTIFY, That I attended deceased from April 11, 1923, to July 17, 1923

that I last saw her alive on July 17, 1923

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(duration) yrs. 3 mos. 7 ds.

CONTRIBUTORY (Secondary): Carcinoma of Pancreas

(duration) yrs. 3 mos. 7 ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? Yes Date of May 1923

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) A. L. Macdonald, M. D.

(Address) 1546 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: July 20 1923

20 UNDERTAKER: Chas. G. Black — ADDRESS: 142 W. North ave

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be given for every person. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. MEDICAL CERTIFICATE OF DEATH is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77618
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

32 D77618
REGISTERED NO.

CITY OF BALTIMORE: (No.) 644 Cakesbury Ave (St.) 9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Marie Pearson

(a) RESIDENCE. NO. 644 Cakesbury Ave ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 19-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 644 Cakesbury Balto. Md.

10 NAME OF FATHER Joseph Chas. Pearson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lillian Marie White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

PARENTS

14 Informant (Address) Joseph C. Pearson 644 Cakesbury.

15 Filed JUL 19 1923

JUL 19 1923 Registrar
ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1923.

17 I HEREBY CERTIFY, That I attended deceased from July 8 1923, to July 16 1923, that I last saw her alive on July 16 1923 and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculer meningitis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Toxaemia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Examination of spinal fluid.

(Signed) Geo A Bauden, M. D.

7/17. 1923 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 19 1923

20 UNDERTAKER ADDRESS
George J. Rust 1735 Hanford Ave.

N. B.—WRITE PLAINLY, WITH ink supplied. AGE, mation should be carefully given, so that it CAUSE OF DEATH plain terms, so that it TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D77619

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ D77619

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1641 N. Appleton St. 15 WARD)

2-FULL NAME Jacob Labowitz

(a) RESIDENCE NO 1641 N. Appleton ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Labowitz

6 DATE OF BIRTH (month, day, and year) about 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Sam Labowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Lubel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs. Labowitz
(Address) 1641 N. Appleton St.

15 Filed JUL 19 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 192 3

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart failure

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) no history

(duration) yrs. mos. ds.

(Signed) J. J. Kennedy, M. D.
(Coroner.)

July 19, 192 (Address) 700 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pikesville Friendship Cemetery	7/19/23 192
20 UNDERTAKER	ADDRESS
Jake Lewis	1459 E Balto N

CAUSE OF DEATH in plain terms, so that it may be understood by the public. Abbreviations and terms peculiar to the profession should not be used. ATTENTION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77620

CERTIFICATE OF DEATH.

49 D77620

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728 N. Gay Street ST. 24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella M. Ritchie

(a) RESIDENCE NO. 214 E. Cross St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Clarence B. Ritchie

6 DATE OF BIRTH (month, day, and year): 10/8/1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 0.3.1

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Thomas Craig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Emmanda Crouch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Clarence B. Ritchie

(Address) 214 E. Cross St

15 Filed JUL 19 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18 1923

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1923, to July 18, 1923

that I last saw h alive on July 17, 1923

and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung

Carcinoma of Brain

(Origin not known)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ..... unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) Fred Ruzicka, M. D.

(Address) 600 N. Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: 7/21/1923

20 UNDERTAKER: Albert L. Hiltz Jr — ADDRESS: 1606 N. Chester St

N. B.—WRITE PLAINLY, WITH INK. AGE should be carefully supplied. Exact statement of deceased's mation should be carefully supplied. AGE that it may be properly classified. CAUSE OF DEATH in plain terms, so that i TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77621

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D77621

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1330 Mosher ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. F. Sample

(a) RESIDENCE NO. 1330 Mosher ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY. Words should be spelled out. AGE should be carefully supplied. Exact statement of desired information should be carefully supplied. AGE should be stated so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A Sample

6 DATE OF BIRTH (month, day, and year) Apr 5- 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	59	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Accomac Co. Va

PARENTS

10 NAME OF FATHER Isaac Sample

11 BIRTHPLACE OF FATHER (city or town) (State or country) Accomac Co. Va.

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Accomac Co. Va

14 Informant Mary A. Sample

(Address) 1330 Mosher

15 Filed JUL 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 17, 1923, to July 18, 1923, that I last saw h alive on July 17, 1923 and that death occurred, on the date stated above, at 2.35 A m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Va.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown, M. D.

7/18, 1923 (Address) 1837 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harborton Co. Va. DATE OF BURIAL July 19 1923

20 UNDERTAKER Sam'l H. Chase & Son ADDRESS 1400 Mosher

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77622

CERTIFICATE OF DEATH.

129

REGISTERED NO. D77622

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Mem. Hospital ST. 27 WARD)

2-FULL NAME Aaron J. Oppenheim.

(a) RESIDENCE NO. Cor. Park Heights & Slade ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

N. B.—WRITE PLAINLY. Every question should be answered. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated. Information should be carefully supplied. AGE should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Betsy Oppenheim

6 DATE OF BIRTH (month, day, and year) Dec. 26. 184x

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
8x	80	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Joseph Oppenheim.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mohler.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Isaac Oppenheim (Address) Pk. Heights & Slade Ave

15 Filed JUL 19 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/18/ 1923.

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1923, to July 18, 1923.

that I last saw him alive on July 18, 1923,

and that death occurred, on the date stated above, at 3.35 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia.

(duration) 0 yrs. 0 mos 7 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? old

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Jno. F. Sunday Jr., M. D.

, 19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem. DATE OF BURIAL 7/19/ 1923

20 UNDERTAKER David Sondheim ADDRESS 118 W. Mt. Royal Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Interstitial
Nephritis

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77623

CERTIFICATE OF DEATH.

161-001 D77623

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 Eric ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Brown

(a) RESIDENCE NO. 1515 Eric ST, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and ~~year~~) July 9th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) 1515 Eric St.
(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charlie Brown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Rosetta Brown

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co
(State or country) Md.

14 Informant

(Address)

15 Filed JUL 19 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9th, 1923, to July 17th, 1923, that I last saw ~~he~~ alive on July 15th, 1923 and that death occurred, on the date stated above, at 8.00 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity 28 weeks.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis H. Douglass, M. D.

7-17-1923 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

HOPKINS HOSPITAL

20 UNDERTAKER — ADDRESS

Commissioner Health

JUL 19 1923

F. B.—WRITE PLAINLY, WITH INK. ... AGE should be stated EXACTLY. ... mation should be carefully supplied. AGE should be properly classified. Exact statement of ... CAUSE OF DEATH in plain terms, so that it may be ... TION is very important. See instructions on back of ... ck of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77624 / 62058

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77624

CERTIFICATE OF DEATH.

137

1-PLACE OF DEATH Johns Hopkins Hospital.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO.) ? ST., 17 WARD)

2-FULL NAME Lulu Clark

(a) RESIDENCE NO. 419 New St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~yrs.~~ ~~mos.~~ ~~ds.~~ How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE of Richard Clark

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work A. W. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant JOHNS HOPKINS HOSPITAL (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 19 1923, 19 Registrar Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 11th, 19 23, to July 17th 19 23.

that I last saw her alive on July 17th 19 23

and that death occurred, on the date stated above, at 1:20 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc with Tuberculosis pedicle - right

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Paralytic ileus

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Yes Date of June 13-1923

Was there an autopsy? Yes

What test confirmed diagnosis? Smears & Gaffky plate

(Signed) ... M. D.

, 19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL JUL 19 1923

20 UNDERTAKER Commissioner Health.

ADDRESS

For Wm. E. Woodall

N. B.—WRITE PLAINLY, WITH INK. ... AGE should be carefully supplied. Exact statement of ... mation should be carefully supplied. AGE ... that it may be properly classified. ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ... ns on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77625

CERTIFICATE OF DEATH.

D77625

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3723 Park Heights Ave. (ST.) (WARD) 15

2-FULL NAME Samuel Crapin Appleby

(a) RESIDENCE. (No.) 3723 Park Heights St. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 10 mos. 3 ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Appleby

6 DATE OF BIRTH (month, day, and year) Sept 14 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Office-clerical and Newspaper Reporter

(b) General nature of industry, business, or establishment in which employed (or employer): Newspaper

(c) Name of employer: Retired 6 years Baltimore, Md

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER: Andrew Jackson Appleby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md

12 MAIDEN NAME OF MOTHER: Margrita Hinkle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Clara Appleby (Address) 3723 Park Heights Ave.

15 Filed JUL 19 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1 1923 to July 17 1923.

That I last saw him alive on July 17 1923.

And that death occurred, on the date stated above, at 11.45A m.

The CAUSE OF DEATH* was as follows:

Malignancy of Prostate and Bladder

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (secondary) Malignancy of Stomach (duration) yrs. mos. 2 months ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. R. Johnson M. D.

(Address) 3928 Park Hts Ave. 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	July 20 1923
20 UNDERTAKER	ADDRESS
Fickler & Fickler	739 Eager

B.—WRITE PLAINLY. All items should be carefully supplied. Age information should be carefully supplied, so that it may be properly classified. Exact statements CAUSE OF DEATH in plain terms, so that TION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77626

D77626

CERTIFICATE OF DEATH.

145-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Susie Cooper

(a) Residence No. 2712 E. Madison St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of John F Cooper

6-DATE OF BIRTH (month, day and year) June 1889

7-AGE. 33 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Martin O'Malley

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Mass

12-MAIDEN NAME OF MOTHER. Mary Owings

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14- (Informant) Hospital Record

(Address) John F Cooper 2712 E Madison St

15- Filed JUL 19 1923 19 Registrar. Robert P. Harrison Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/19/23

17- I HEREBY CERTIFY, That I attended deceased from 7/3/23, 19 to 7/19/23, 19

that I last saw her alive on 7/19/23 19

and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

Uremia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pregnancy (Placenta Previa)

(Duration) yrs. mos. 8 ds.

18-Where was disease contracted if not at place of death? Caesarean Section 7/3/23

Did an operation precede death? Yes Date of 7/3/23.

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) K. W. Goldy M. D

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL. July 21 1923

20-UNDERTAKER. Wm. Cook ADDRESS 502 E Biddle

B.—WRITE plainly. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Brought 203 E Preston St.

91-002 D77627

D77627

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2021 Eutaw Pl ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Bechtold

(a) RESIDENCE NO. 2021 Eutaw Pl ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Holzapfel

6 DATE OF BIRTH (month, day, and year) April 19 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery man

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Bechtold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Jeannette Bechtold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Henry Bechtold

(Address) 2021 Eutaw Pl

15 Filed JUL 19 1923, 19 Registrar

Robert F. Garrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1923

17 I HEREBY CERTIFY, That I attended deceased from July 15, 19 23 to July 15, 19 23, that I last saw h alive on July 15, 19 23, and that death occurred, on the date stated above, at 7:40 m.

The CAUSE OF DEATH* was as follows:

Gangrene (Senile) of Right Leg

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 10 yrs (?) mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm R. Geraghty M. D.

7/19. 1923 (Address) 203 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	July 21 1923
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Balto

N. B.—WRITE PLAINLY. WITH INK. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. SIGNATURE is very important.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77628

CERTIFICATE OF DEATH.

161-001 ✓ D77628

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 853 W 34 ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret P. Schneider

(a) RESIDENCE. NO. 853 W 34 ST. 13 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 7-17-23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boston Mass

PARENTS

10 NAME OF FATHER John Schneider

11 BIRTHPLACE OF FATHER (city or town) (State or country) Boston Mass

12 MAIDEN NAME OF MOTHER Margaret Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boston Mass

14 Informant John Schneider

(Address) 853 W 34

15 Filed JUL 19 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-19 1923

17

I HEREBY CERTIFY, That I attended deceased from 7-17, 1923, to 7-19, 1923; that I last saw h alive on 7-18, 1923; and that death occurred, on the date stated above, at 5 9 m.

The CAUSE OF DEATH* was as follows:

Premature Gestation

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical sign

(Signed) C T Hedgdat M. D.

19 (Address) 2701 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	July 19 1923

20 UNDERTAKER Chenoweth & Son Address Calvert St

N. B.—WRITE PLAINLY. Words should be carefully supplied. AGE should be stated in every case. Exact statement of information should be carefully supplied. AGE should be stated in every case. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77629

CERTIFICATE OF DEATH.

145-01 D77629

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 McCulloh ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Caroline Davis

(a) RESIDENCE NO. 1808-E-28th St. Balto Md.
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of E. C. Davis

6 DATE OF BIRTH (month, day, and year) 7-22-'98

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
	24	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Jno L. Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Mary L. Crist

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto -

14 Informant Sister.

(Address) 1804-E. 28th St.

15 Filed JUL 19 1923, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-17-23 19

17 I HEREBY CERTIFY, That I attended deceased from 7-16-23, 19 . to 7-17-23, 19 ,

that I last saw her alive on 7-17-23, 19 ,

and that death occurred, on the date stated above, at 9 A.M. P.M.

The CAUSE OF DEATH* was as follows:

Pregnancy.

(duration) yrs. 8 mos 7 ds.

CONTRIBUTORY (Secondary) Eclampsia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 7-16-23.

Was there an autopsy? None

What test confirmed diagnosis? Clinical symptoms

(Signed) [illegible] M. D.

, 19 (Address) Mt Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 19 1923
UNDERTAKER	ADDRESS
Chenoweth & Son	Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of DATE OF BIRTH is very important. See instructions on back of certificates.

D77630

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D77630

Registered No. C 129

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 732 Pacific Ave. ST. 13 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Lavina Newcomer

(Residence in Baltimore: No. 732 Pacific Ave. St.: 17 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
female	white	married

6 DATE OF BIRTH Dec 5/1860 (Month) (Day), 1 (Year)

7 AGE 62 yrs. 7 mos. 14 ds. If LESS than 1 day, hrs. or min.

8 OCCUPATION
(a) Trade, profession, or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Penna

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (State or country): "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (State or country): "

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank P. Newcomer (husband)

(Address) 732 Pacific Ave.

15 Filed ... 191 Robert P. Harrison, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH July 19/23 (Month) (Day), 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9/23, 191, to July 18/23 191, that I saw her alive on July 18/23, 191, and that death occurred, on the date stated above, at 3.30 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(Duration) yrs. mos. ds

Contributory (SECONDARY) Chronic Nephritis probably months 1 yrs. mos. ds.

(Signed) J. H. Waller M. D.

7/19/23, 191 (Address) 508 E. North Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: St Marys Hampden — DATE OF BURIAL: July 20 192[illegible]

20 UNDERTAKER: Ehenowelth Son — ADDRESS: Chestnut [illegible]

NB.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE REGISTER

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77631 ✓

D77631

CERTIFICATE OF DEATH.

X 113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (NO. 13 ST., WARD)

2-FULL NAME Melvin Anderson

(a) RESIDENCE NO. 3514 Poole ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Washington (State or country) D. C.

PARENTS

10 NAME OF FATHER Earnest Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Earnest Anderson (Address) 3514 Poole St.

15 July 19 1923 . 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 12th, 1923, to July 19th, 1923, that I last saw him alive on July 19th, 1923, and that death occurred, on the date stated above, at 1 30 A. m.

The CAUSE OF DEATH* was as follows:

Acute diarrhoea, apparently non-specific

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical course

(Signed) [illegible] M. D.

July 19 1923 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden DATE OF BURIAL July 20, 23

UNDERTAKER Ehrenwerth Son Lakeside ADDRESS

B.—WRITE PLAINLY. Ink should be used. Exact statement of OCCUPATION should be stated. AGE should be carefully supplied. AGE should be carefully supplied

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77632 ✓ D77632

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2058 Aiken ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harold Taddeo

(a) RESIDENCE. No. 2058 Aiken ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 24, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Alexander Taddeo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Clara Freed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Alexander Taddeo
(Address) 2058 Aiken St

15 Filed . 19 Robert P. Harrison, Registrar

JUL 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1923

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1923, to July 18, 1923, that I last saw him alive on July 18, 1923, and that death occurred, on the date stated above, at 3, 9. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. T. Zimmerman D.

. 19 (Address) 2258 Harford 12

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	July 20 1923
20 UNDERTAKER	ADDRESS
George J. Smith	1532 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL BLANKS should be stated EXACTLY. PARTICULAR attention is called to the following: AGE should be carefully supplied. OCCUPATION should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PARTICULAR attention is called to the following: AGE should be carefully supplied

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77633 ✓ 31 D77633

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Tuberculosis Hospital ST. 17 (WARD)

2-FULL NAME William Smith

(a) RESIDENCE NO. 1062 Argyle ave. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Unknown 3 years mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) Hospital Records M.T.H.

15 Filed JUL 19 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1923

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1923, to July 16, 1923, that I last saw him alive on July 16, 1923, and that death occurred, on the date stated above, at 8.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous peritonitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? B. T. in sputum. X-ray

(Signed) Frances K. Partington M. D.

(Address) Municipal Tbc. Hospital 7-17-23

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va

DATE OF BURIAL July 20 1923

20 UNDERTAKER Edward Bryan

ADDRESS 631 Orleans st

B.—WRITE PLAINLY, WITH INK. AGE should be carefully supplied. Exact statement of birth-day, month and year should be stated. Information should be carefully supplied. AGE so that it may be properly classified. Exact statement of birth-day, month and year should be stated. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of birth-day, month and year should be stated. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77634

CERTIFICATE OF DEATH.

31 D77634

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Tuberculosis Hospital STR. 6 WARD)

2-FULL NAME Mary Frazier

(a) RESIDENCE NO. 110 N. Dallas st. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Henry Curriston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary Lingham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address) M.T.H.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1923, to July 17, 1923, that I last saw h er alive on July 17, 1923, and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 8 mos ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no. Date of .....

Was there an autopsy? no.

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis L. Dalrymple M. D.

7-17-23 (Address) Municipal Tbc. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bury cemetery

DATE OF BURIAL July 20 1923

ADDRESS 1631

20 UNDERTAKER Edward Bryan

N. B.—WRITE PLAINLY, WITH INK. AGE should be stated EXACTLY. Exact statement of AGE should be carefully supplied. Information should be carefully supplied, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

JUL 19 1923

Permit

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77635

CERTIFICATE OF DEATH.

74-02 D77635

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1701 N. Calvert ST., 17 WARD)

2-FULL NAME Virginia Ann Baylies

(a) RESIDENCE NO. 1701 N. Calvert ST., 17 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Baylies

6 DATE OF BIRTH (month, day, and year) Sept 7-1839

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	83	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Kingston, Somerset County, Maryland

PARENTS

10 NAME OF FATHER Stephen Blackburn Powell

11 BIRTHPLACE OF FATHER (city or town) Somerset Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Waters

13 BIRTHPLACE OF MOTHER (city or town) Somerset Co (State or country) Md.

14 Informant John H. Baylies
(Address) 1701 N. Calvert St

15 JUL 19 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1923, to July 18, 1923, that I last saw him alive on July 18, 1923, and that death occurred, on the date stated above, at 3-30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis (duration) yrs. mos 1/2 ds.

CONTRIBUTORY (Secondary) Mitral heart disease (duration) 20 yrs. Unknown mos. ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Paralysis of right side.

(Signed) Jas. McCreight M. D.

(Address) 1800 N. Charles July 14 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL July 20 1923

20 UNDERTAKER H. W. Jenkins Sons Co. ADDRESS McCulloh & Cheltenham

N. B.—WRITE PLAINLY, WITH INK. AGE should be stated EXACTLY. Exact statement of AGE should be carefully supplied. AGE should be carefully supplied. Exact statement of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77636 ✓ 32 D77636

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1900 Walbrook Ave ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Carolyn Munder.

(a) RESIDENCE NO. 1900 Walbrook Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. 3 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 5. 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Geo. Munder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Munder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Geo. Munder

(Address) 1900 Walbrook Ave

15 Filed JUL 19 1923, 19

Robert P. Harrison,

Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1923

17

I HEREBY CERTIFY, That I attended deceased from June 24th, 1923, to July 18th, 1923.

that I last saw her alive on July 18th, 1923,

and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

meningitis

(Acute)

(duration) yrs. mos 24 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none.

(Signed) Chas. H. Burkhart, M. D.

July 18 1923 (Address) 1100 E. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: July 21, 1923

20 UNDERTAKER: Mr & Mrs John H. Penfelder

ADDRESS: 801 E. Fayette

CAUSE OF DEATH should be stated EXACTLY. AGE should be carefully supplied. It may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Tuberculous

(See addendum over)

D77637

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77637

D77637

CERTIFICATE OF DEATH.

8 177

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE. (No. 1508 E. Lafayette Ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Domenica De Silvio
~~Mary~~ Decilveo

(Residence in Baltimore: No. 1508 E. Lafayette Ave St.; yrs. 30 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	~~Married~~ Widowed

6-DATE OF BIRTH. Dec. (Month) 15/1862 (Day) 1..... (Year)

7-AGE. 61 yrs. 7 mos. 3 ds. If LESS than 1 day, ...hrs. or .....min.

8-OCCUPATION
(a) Trade, profession, or particular kind of work..... at home
(b) General nature of industry, business, or establishment in which employed (or employer)..... 037

9-BIRTHPLACE. (State or Country). Italy

PARENTS.

10-NAME OF FATHER. Joseph De Silvio Decilveo

11-BIRTHPLACE OF FATHER. (State or Country). Italy

12-MAIDEN NAME OF MOTHER. Mary Guesippe

13-BIRTHPLACE OF MOTHER. (State or Country). Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Ruth

(Address) 1735 Harford Ave

15- Filed JUL 19 1923 192.....

Robert P. Harrison, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 18/23 (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(was recivering from tonsillitis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) swallowed Iodine by mistake (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

7/19 1923 (Address) 508 E Mad Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
New Cathedral Cem 7-20 1923

20-UNDERTAKER. ADDRESS
Geo J. Ruth 1735 Hanford Ave

CB.—Every item of information should be carefully and accurately given, so that it may be properly classified. Exact statement should be made in plain terms, so that it may be properly classified. Exact statement should be made in plain terms, so that it may be properly classified. Exact statement should be made in plain terms

JUL 23 1923

Personally appeared before me this 23rd day of July 1923. Mr Geo Ruth Informant. On the Death Certificate of Mary Declared Who makes affadivit that the name should be Domenica Di Silvio.

Seal ~~George J. Ruth.~~

Seal. George H Grese
notary Public

...

...

...

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77638

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

H26 D77638

Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hospital St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Percy Green .....

(Residence in Baltimore: No. 106 Shipley Catonsville Md. St.; yrs. ..... mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (write the word.)
male	col	

6-DATE OF BIRTH. ..... Dec. 4/1918 ....., 1.....
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
4 yrs. 7 mos. 15 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, Percy Green

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER, Irene Cook

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Percy Green

(Address) Catonsville Md.

15- Filed ..... 19.. Robert P. Harrison, Registrar.

DL 19 1923 Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 19/23 ....., 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said .....
(Inquest, autopsy or inquiry.)
find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Peritonatis- Primary (Probably blood stream infection. No other findings at autopsy at hospital)

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration).....yrs.....mos.....ds.

(Signed) J. S. Howe M. D.
(Coroner.)

7/19/23 192.... (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Western Star Cem DATE OF BURIAL, July 22 1923.

20-UNDERTAKER, Easton Sons & Stucky ADDRESS City

N B—Every item of information should be carefully supplied. Exact statement is required that it may be properly classified. Exact statement should be made in state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77639

CERTIFICATE OF DEATH.

38 D77639

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 Willow ave. ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. Ruth

(a) RESIDENCE No. 516 Willow ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alverta J. Ruth

6 DATE OF BIRTH (month, day, and year) June 22-1855

7 AGE	Years	Months	Days	If LESS than 1 day,.....hrs. or min.
	68		26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Gardner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md.

PARENTS

10 NAME OF FATHER Francis J. Ruth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Eckdamer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Josephine B. Dougherty (Address) 516 Willow ave.

15 July 19 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1923

17 I HEREBY CERTIFY, That I attended deceased from 7-12, 1923 to 7-18, 1923.

that I last saw h, m alive on 7-17, 1923.

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senile

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Friend, M. D.

July 19 1923 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Park Wood Cem.	July 20 1923

20 UNDERTAKER Wm. L. Black ADDRESS 927 N. Broadway

N.B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of DATE OF DEATH, mation should be carefully supplied. AGE, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DATE OF DEATH, TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77640

CERTIFICATE OF DEATH.

X 101-08

D77640

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Dunlap.

(a) RESIDENCE NO. 47 Pow. Fulton Ave ST., WARD St. Albins W. Va
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. 1 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)? 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
55	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Not Known

9 BIRTHPLACE (city or town) (State or country): U.S.A.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Hospital Records
(Address)

15 Filed ..., 19... Registrar Robert F. Harrison, Burial Permit Clerk.

JUL 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19 1923

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1923, to July 19, 1923, that I last saw him alive on July 19, 1923, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 14 ds.?

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward A. Kulawski, M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Albins W. Va — DATE OF BURIAL: July 19 1923

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 1521 W. Lombard

CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77641

D77641

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3/v

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal tuberculosis Hospital 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Horace Sample

(a) RESIDENCE NO. 1615 W. Franklin st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897 ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Marshall Sample

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Hattie Terry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records

(Address) M.T.H.

15 Filed JUL 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1923, to July 17, 1923, that I last saw him alive on July 17, 1923, and that death occurred, on the date stated above, at 4.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) Francis D'Adaglianca, M. D.

7-17-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
J.W.T. Auburn Cem	7-20 1923
20 UNDERTAKER	ADDRESS
Daniel Easton	Cam

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

D77642

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77642

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 774 Schroeder St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Gorham

(Residence in Baltimore: No. 774 Schroeder St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	colored	Single

6-DATE OF BIRTH. about (Month) (Day) 1900 (Year)

7-AGE. 23 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Canvas Co

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Dis. Phys

(Address) Canton Co.

15-

Filed JUL 20 1923 192.... ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

THE MORGUE

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 13 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inq (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

192.... (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. UNIVERSITY OF MARYLAND DATE OF BURIAL. July 19th 1923

20-UNDERTAKER. Commissioner Health. ADDRESS

N. B.—Every item of information should be carefully supplied. Exact statement of facts may be properly classified. Exact statement of facts may be properly classified. Exact statement of facts may be properly classified

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77643

38 D77643

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 Gorsuch Ave ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander James Revelle

(a) RESIDENCE. NO. 519 Gorsuch Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sally J. Long

6 DATE OF BIRTH (month, day, and year) May 10, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
~~68~~ 68		2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General utility Statesman 073

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Pennsylvania R.R.

PARENTS

9 BIRTHPLACE (city or town) (State or country) Somerset Co. Md

10 NAME OF FATHER Geo. C. Revelle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Somersett Co.

12 MAIDEN NAME OF MOTHER Martha White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Somerset Co.

14 Informant Sally J. Revelle

(Address) 519 Gorsuch Ave.

15 Filed JUL 20 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1923

17 I HEREBY CERTIFY, That I attended deceased from January, 1916, to July 15, 1923, that I last saw h~~im~~ alive on July 15, 1923, and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Pabes Dorsalis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

July 18, 1923 (Address) 2005 E Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	July 21 1923

20 UNDERTAKER Josiah Leppo ADDRESS 1600 W North Ave

N. B.—WHITE PAPER must be carefully supplied. AGE should be given in years, months and days. Exact statement of DECEASED'S OCCUPATION should be properly classified. Exact statement of place of death and full information should

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Syphilis

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77644

CERTIFICATE OF DEATH.

113 D77644

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 920 McCulloh St. (St.) 11 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Robinson

(a) RESIDENCE. No. 920 McCulloh St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 8 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Wm Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER May Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant (Address) May Robinson 920 McCulloh St

15 Filed JUL 20 1923 ROBERT R. KRAMER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-19 1923

17 I HEREBY CERTIFY, That I attended deceased from 7-18, 1923, to 7-18, 1923, that I last saw him alive on 7-18, 1923, and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Entero-Colitis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William L Harris, M. D.

7/19, 1923 (Address) 1200 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	July 10 23
20 UNDERTAKER	ADDRESS
Mrs. R. C. Elliott	25 Eastland Ave

N. B.—WRITE PLAINLY. Information should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D77645

CERTIFICATE OF DEATH.

Registered No. D77645

1-PLACE OF DEATH

City of BALTIMORE: (No. 120 So. Caroline St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bettie Evans

(Residence in Baltimore: No. 120 So. Caroline St.; 5 yrs. ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Unknown (Month) (Day) (Year)

7-AGE: about 49 yrs. ... mos. ... ds.

If LESS than 1 day: ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country): Va

PARENTS:

10-NAME OF FATHER: Edmund Stokes

11-BIRTHPLACE OF FATHER, (State or Country): Va

12-MAIDEN NAME OF MOTHER: Harriet Ray

13-BIRTHPLACE OF MOTHER, (State or Country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt Evans

(Address) 120 So Caroline St

15-

Filed JUL 20 1923 19... ROBERT R. KRAMES Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 18 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, Autopsy or Inquiry.) find that said deceased came to ... on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) Jno. B. Fulton M. D.

Coroner

July 18 1923 (Address) Curtis Bay Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL: Laurel Cemetery

DATE OF BURIAL: July 20 1923

20-UNDERTAKER: Mrs. Chas. B. Jones

ADDRESS: 172 Eastland Ave.

N. B.—Every item of information should be carefully supplied. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D 77646 — Jones — D 77646 — 90

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital WARD) 14

2-FULL NAME John R Jones

(a) RESIDENCE No. 622 W. Lafayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M06	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence James

6 DATE OF BIRTH (month, day, and year) August 7 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister 065

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Talbot County Maryland

PARENTS

10 NAME OF FATHER Isaac James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Denby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Florence James Wife (Address) 622 W. Lafayette Ave

15 JUL 20 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1923

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1923, to July 19, 1923, that I last saw him alive on July 19, 1923, and that death occurred, on the date stated above, at 2:10 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? B.P. & Symptoms

(Signed) J A Schwartz, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Cemetery	July 22 1923
20 UNDERTAKER Mrs. R.C. Elliott	ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 D77647

D77647

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 W Saratoga ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Rives Lahs

(a) RESIDENCE NO. 1521 Bolton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~, (write the word)
Male	White	Single

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year) 1864-10-6

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	58	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coffee Broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert Lehr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary F. Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wheeling W. Va.

14 Informant Dr Louis Lehr (Address) Washington D.C.

15 JUL 20 1923 ROBERT A. KRANTZ Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/18 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1922 to 7/18 1923.

that I last saw him alive on 7/15 1923.

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs few minutes mos ds.

CONTRIBUTORY (Secondary) Arterio sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 106 W Saratoga

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical history & Symptoms

(Signed) H. B. Kleba M. D.

(Address) 1008 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 7-20 1923

20 UNDERTAKER Evergreen Jenkins Sons Co

ADDRESS McCulloh & Orchard

N. B.—WRITE PLAINLY. WORDS should be written in full. AGE should be carefully supplied. Exact statement of OCCUPATION should be carefully supplied

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77648

CERTIFICATE OF DEATH.

91-802 D77648

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Gresser

(a) RESIDENCE. No. 1221 E. Madison ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Gresser

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work old age

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hyman Gresser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Liba Milkes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Balt St

15 Filed JUL 20 1923 ROBERT R. KRAUTZ Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1923

17 I HEREBY CERTIFY, That I attended deceased from June 25 . 1923 . to July 19 . 1923 . that I last saw him alive on July 19. . 1923 . and that death occurred, on the date stated above, at 11:05 p m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chron. Tbc. basal infection

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical & lab.

(Signed) Isidor D. Fox, M. D.

. 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale DATE OF BURIAL July 20 1923

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balt St

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be stated immediately after name. Exact statement of OCCUPATION

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D77649 HEALTH DEPARTMENT—CITY OF BALTIMORE D77649

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 114 S. Carey St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rinard Lockard

(a) Residence No. 114 S. Carey St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. dt. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 25 1921

7-AGE. 1 yrs. 11 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): none
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: George Lockard

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore

12-MAIDEN NAME OF MOTHER: Madeline Broom

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore

14- (Informant) George Lockard
(Address) 114 S Carey St

15- FILED JUL 20 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 19th 23

17- I HEREBY CERTIFY, That I attended deceased from 7/16/23 to 23 to 7/19/23 1923.
that I last saw him alive on 7/14/ 1923
and that death occurred, on the date stated above, at 10 30 A m.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Measles

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [signature] M. D.
7/20/23 19 (Address) 3022 Forest

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: July 21st 1923

20-UNDERTAKER: Robert Brooks & Son — ADDRESS: Calhoun & Hollins sts

N. B.—Write plainly. AGE should be carefully supplied. Exact statement of OCCUPATION should be given in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77650 D77650

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 99-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Colonial Hospital Baltimore

CITY OF BALTIMORE: (No. ~~1722 Morton St.~~) ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franklin Price

(a) RESIDENCE NO. 1722 Morton St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE Colored

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced. (write the word)~~ Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Beatrice Price

6 DATE OF BIRTH (month, day, and year) Apr 7, 1901

7 AGE 21 Years 8 Months 11 Days / If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sobner 040

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank Price

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md

12 MAIDEN NAME OF MOTHER Rella Griffin ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md

14 Informant (Address) Grace Lenox 1722 Morton St

15 Filed JUL 20 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/18/23

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1923, to July 18, 1923, that I last saw him alive on July 18, 1923, and that death occurred, on the date stated above, at 8. P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Heart

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) ~~1~~ 2 yrs. mos. 4 1/2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) I. P. Robinson M. D.

, 19 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Centreville md — DATE OF BURIAL July 20 19 23

20 UNDERTAKER Joseph a Farrell — ADDRESS 2319 Eutaw

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. Exact statement of occupation should be carefully supplied. AGE should be carefully supplied. AGE should be stated in years, months and days, so that it may be properly classified. Exact statement of occupation should be carefully supplied. AGE should be carefully supplied. AGE should be stated in years, months and days, so that it may be properly classified. CAUSE OF DEATH in plain terms

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77651

D77651

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Vol. of Univ. Hospital ST.: 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Yaekel

(a) RESIDENCE. No. 504 N Green ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
(or) WIFE of Joseph Yaeckel

6 DATE OF BIRTH (month, day, and year) March 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home Work 037
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENT'S

10 NAME OF FATHER Carlton Burgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Meyers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Alice Ellis
(Address) 3116 Monticello Ave

15 JUL 20 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-19 1923

17 I HEREBY CERTIFY, That I attended deceased from 7-17, 1923, to 7-19, 1923, that I last saw h[er] alive on 7-19, 1923, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular heart disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Attending Phy

(Signed) Albert J Conley, M. D.

, 19 (Address) Vol. of Univ. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 20 1923

20 UNDERTAKER Harry N. Witzke ADDRESS 1531 W. Lombard

N. B.—WARNING—The information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77652 HEALTH DEPARTMENT—CITY OF BALTIMORE D77652

CERTIFICATE OF DEATH

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard + Green ST.) 21 (WARD)

REGISTERED NO. 146

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Blackburn

(a) RESIDENCE NO. 607 Bergundy ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1st 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18 years	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Blackburn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Daisy Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) John Blackburn 607 Bergundy St.

45 Filed JUL 20 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-17 1923

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1923, to July 15, 1923, that I last saw her alive on July 17, 1923, and that death occurred, on the date stated above, at 7:05 p.m.

The CAUSE OF DEATH* was as follows:

Toxic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Puerperal peritonitis

(duration) yrs. mos. 1 ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) C. Heyler M.D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery DATE OF BURIAL July 20 1923

20 UNDERTAKER Mrs. Scott Hopkins ADDRESS 406 N. Eutaw

Page 1299

N. B.—WRITE PLAINLY, with pen and ink. All items must be carefully supplied. AGE should be stated EXACTLY. Information should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77653 HEALTH DEPARTMENT—CITY OF BALTIMORE D77653

CERTIFICATE OF DEATH. 159-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3631 Mapel Av ST. 13 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Louis Soubmer

(a) RESIDENCE. No. 3631 Mapel ST., 13 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write this word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-4-23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) ddd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt City

PARENTS

10 NAME OF FATHER Ernest Seibert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Ruth Keeney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt City

14 Informant Ernest Seibert (Address) 3631 Mapel Av

15 Filed JUL 20 1923 ROBERT P. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-19 1923

17 I HEREBY CERTIFY, That I attended deceased from 7-4 1923, to 7-19 1923, that I last saw h alive on 7-18 1923 and that death occurred, on the date stated above, at 3.50 p.m.

The CAUSE OF DEATH* was as follows:

Potent Tumor Cerebi

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Pathologist

(Signed) E. T. Campbell M. D.

1923 (Address) 320 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Odd Fellows Cem Md	July 20 1923
20 UNDERTAKER	ADDRESS
Ehrenworth Son	Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—All information should be stated EXACTLY. PHYSICIANS and UNDERTAKERS should be careful to see that all information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and UNDERTAKERS should be careful to see that it may be properly classified. Exact statement of OCCUPATION of deceased is necessary, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77654

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D77654

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2648 Boone St. St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dolly J. Elliott

(Residence in Baltimore: No. 26ri Boone St. St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (write the word.)
female	col	

6-DATE OF BIRTH. Sept 7/1916 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
6 yrs. 10 mos. 19 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, Richard Elliott

11-BIRTHPLACE OF FATHER, (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Addie Burke

13-BIRTHPLACE OF MOTHER, (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Addie Elliott

(Address) 2648 Boone St.

15- JUL 20 1923 J. L. K. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 18/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

cardiac Dilatation -(Probably valvular Insuffiency from report by Dr. Murgatiroyd)

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J. H. Dallam M. D. (Coroner.)

7/19/23 (Address) 508 E. North Av

*State the Disease Causing Death, or, in deaths from Violent Causes, state (I) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Hill — DATE OF BURIAL, July 20, 1923

20-UNDERTAKER, James N. Lewis — ADDRESS, 307 Fairmount

N. B.—Every item of information should be carefully supplied. Exact statement of occupation is very important. Unless the CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Frederick Gunby

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77655

CERTIFICATE OF DEATH.

X135 D77655

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen Hospital St. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Gunby

(a) RESIDENCE NO. Irvington Va ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Addie M. Gunby

6 DATE OF BIRTH (month, day, and year) Nov 12-1851

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
~~About~~ 71	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER ? Gunby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Fred W.W. Gunby

(Address) Irvington Va

15 Filed JUL 20 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH INK. All information should be carefully supplied. AGE should be stated PARTICULARLY. Exact statement of CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-19-23

17

I HEREBY CERTIFY, That I attended deceased from 7-7-23 19 , to 7-19-23 19 .

that I last saw h in alive on 7-19-23 , 19 ,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Hypertrophied prostate

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilitation

(duration) yrs. mos. 12 hr

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 7-18-23

Was there an autopsy? Prostatectomy

What test confirmed diagnosis? Clinical, Surgical

(Signed) Geo A Tompkins M. D.

, 19 (Address) Md Gen Hospl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Irvington Va	July 20, 23
20 UNDERTAKER	ADDRESS
W Tuckner & Sons	Norfolk Va

Spec.—1-10-21—M&T—1500 Blks.

16H909
D77656

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 49 ✓ D77656

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. .... ST., 7 WARD)

2-FULL NAME Richard F. Liston

(a) RESIDENCE NO. Friendsville, Md. ST., Garrett County. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. —How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 4, 1860.

7 AGE — Years: 62. Months: 8 Days: 14. If LESS than 1 day, hrs. or .... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Farmer 086
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS
10 NAME OF FATHER: John Liston
11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.
12 MAIDEN NAME OF MOTHER: Harriet Ryland.
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed JUL 20 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1923.

17 I HEREBY CERTIFY, That I attended deceased from July 6. 1923. to July 18. 1923. that I last saw him alive on July 18. 1923. and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of the prostate and seminal vesicals

(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Pyelonephritis - Uremia
(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Friendsville, Md.
Did an operation precede death? Yes Date of July 9, 1923
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) Abel Blalock, M. D.
19 (Address) Johns Hopkins Hospital, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friendsville Md. — DATE OF BURIAL: July 20 1923

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 B Way

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185 D77657

REGISTERED NO. .....

D77657

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dolores Flury

(a) RESIDENCE No. 807 S. 6th St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Nov. 4-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	8	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER George Flury

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Theodora Hoek

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant George Flury (Address) 807 S. 6th St.

15 Filed JUL 20 1923 192 ROBERT H. KRAUTER Registrar Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or)~~ inquiry.)

thereon and from the evidence obtained by said ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured Skull

(duration) ..... yrs. ..... mos. 18 hrs

CONTRIBUTORY (Secondary) Fell from porch

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ~~XX~~ Gormley M. D.
(Coroner.)

7-19 1923 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL July 21 1923

20 UNDERTAKER Lilly and Zeiler

ADDRESS 403 S. Wolfe St

mation should be given in plain terms, so that it may be properly classified.
CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificate.
TION is very important

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77658

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77658

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 227 N Pappleton St. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margarita Hilfer

(a) RESIDENCE. NO. 227 N Pappleton St

(Usual place of abode) WARD.

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
84				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hsekpr

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany, Don't Know

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany Don't Know

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant A. J. Mueller (Address) 227 N Pappleton St

15 Filed JUL 20 1923 ROBERT B. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1923

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1923, to July 19, 1923, that I last saw her alive on July 19, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. K. Fenwick, M. D.

7/20 1923 (Address) 117 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 23 1923

20 UNDERTAKER W. M. Roulson ADDRESS 2238 W North

Information should be carefully supplied. Any... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77659

CERTIFICATE OF DEATH.

44 D77659

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 870 Pierce ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Harris

(a) RESIDENCE NO. 870 Pierce ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, ~~widowed~~ or ~~divorced~~ (or) WIFE of Thomas Harris

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min. —
	43 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Washington D.C.
(State or country)

PARENTS

10 NAME OF FATHER Alexander Thomas

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Thomas Harris
(Address) 870 Pierce

15 Filed ..... 19 ..... ROBERT R. KRAUTER Registrar
JUL 20 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 30, 1923, to July 19, 1923, that I last saw her alive on July 17, 1923, and that death occurred, on the date stated above, at 5:45 A m.

The CAUSE OF DEATH* was as follows:

Hepatic Carcinoma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of Dec - 1922

Was there an autopsy? no

What test confirmed diagnosis? Operation Dec 1922

(Signed) William E Burton, M. D.

, 19 (Address) 762 Dolphin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn | DATE OF BURIAL July 24 1923

20 UNDERTAKER Brown Freeland & Schnyder | ADDRESS 1194 N.

N. B.—WRITE PLAINLY, WITH INK. ... should be carefully supplied. AGE should be stated ... mation should be carefully supplied. AGE should be stated ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77660

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77660

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Nursery + Child's Hospital

CITY OF BALTIMORE: (No. Franklin + Schroeder ST., 18 WARD) 16-002 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anita Biggs

(a) RESIDENCE NO. Frederick city Md. ST., WARD Frederick Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1st 1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
1	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland University

PARENTS

10 NAME OF FATHER Chas H. Cabrera

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cent. America.

12 MAIDEN NAME OF MOTHER Ruth Biggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Md

14 Informant Geo. B. Biggs
(Address) Frederick Md

15 Filed JUL 20 1923 Robert P. Harrison, Registrar
Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH INK. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. INFORMATION is very important.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1923

17

I HEREBY CERTIFY, That I attended deceased from June 14, 1923, to July 20, 1923, that I last saw her alive on July 20, 1923, and that death occurred, on the date stated above, at 2:40 A.m.

The CAUSE OF DEATH* was as follows:

Dysentery (bacillary) - Hosmer

(duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? No:

What test confirmed diagnosis? Stool Culture

(Signed) Lawson Hilkins, M. D.

July 20, 1923 (Address) 1014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Frederick Md	July 21 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Calvert

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77661

CERTIFICATE OF DEATH.

113 D77661

REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital

CITY OF BALTIMORE: (No. 24 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Audrey May Stewart

(a) RESIDENCE NO. 261 E Hamburg ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 13th, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Albert Stewart

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Delaware

12 MAIDEN NAME OF MOTHER Nettie Seeger

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Nellie Stewart
(Address) 261 E Hamburg St

15 Filed ... 19 ... Registrar

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19th 1923

17

I HEREBY CERTIFY, That I attended deceased from July 17th, 1923, to July 19th, 1923,

that I last saw h e alive on July 19th, 1923,

and that death occurred, on the date stated above, at 4 45 A. m.

The CAUSE OF DEATH* was as follows:

Acute diarrhoea, probably bacillary.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Extreme malnutrition + marasmus (duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical exam.

(Signed) Jno. F. Timmerman, M. D.

July 21 1923 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A & Co — DATE OF BURIAL July 21/1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH INK. AGE should be stated EXACTLY. Exact statement of DATE OF DEATH should be carefully supplied. AGE should be carefully supplied. Exact statement of DATE OF DEATH in plain terms, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

JUL 20 1923

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77662 ✓ D77662

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 N. Bradford St.: 7 Ward)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Hores (Hures)

(a) RESIDENCE. No. 911 N. Bradford St.. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Hores

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER George Hores

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Anna Hores

(Address) 911 N. Bradford St

15 Filed JUL 20 1923 19 Robert T. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1923

17

I HEREBY CERTIFY, That I attended deceased from June 12, 1923 to July 18, 1923.

that I last saw h[illegible] alive on July 17, 1923.

and that death occurred, on the date stated above, at 4 35 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory findings

(Signed) Vincent K. Sobska, M. D.

, 19 (Address) 845 N. Robinson St. City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 21 1923
20 UNDERTAKER	ADDRESS
Frank Crocker Son	1906 Eastland Ave

S. B.—WRITE PLAINLY. Answers to questions should be carefully supplied. Age should be stated in years, months and days. Exact statement of date of birth should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of place of death is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77663

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77663

CERTIFICATE OF DEATH.

57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2148 Washington Blvd ST., 9 WARD)

2-FULL NAME Annie E. Blondell

(a) RESIDENCE NO. 2148 Wash. Blvd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dennis J. Blondell

6 DATE OF BIRTH (month, day, and year): Dec 4 -

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): Dell

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Joseph Wife Laughlin

PARENTS

10 NAME OF FATHER: Balto Md

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Annie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Anna Culbertson

(Address) 2148 Wash. Blvd.

Filed JUL 20 1923, 19 Robert F. Harrison, Registrar

Special Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18 1923

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1923, to July 18, 1923, that I last saw her alive on July 18, 1923 and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urine

(Signed) Raymond J. Glenn, M. D.

July 18 1923 (Address) Bel Glenn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 7/23 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 512 E North Ave

GENERAL.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. Information should be carefully supplied. Exact statement of OCCUPATION is it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77664 ✓ 118-001 D77664

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1231 Sargeant St. ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George L. Wolf

(a) RESIDENCE NO. 1231 Sargeant St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Minnie C. Wolf

6 DATE OF BIRTH (month, day, and year) Sept. 27" 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	79	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Wolf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Weikert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Minnie C. Wolf (Address) 1231 Sargeant St.

15 Filed JUL 21 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18" 19 23

17

I HEREBY CERTIFY, That I attended deceased from July 16, 1923, to July 18, 1923, that I last saw her alive on July 18, 1923, and that death occurred, on the date stated above, at 9.05 P m.

The CAUSE OF DEATH* was as follows:

Strangulated Gall
(Possibly Gangrenous)
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Strangulated Hernia
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hoyland Drain, M. D.

7/19 19 23 (Address) 1227 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 21 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Balto St

B.—WRITE plainly. All items should be carefully supplied. AGE should be stated in years, months and days. Exact statement of CAUSE OF DEATH may be properly classified. See instructions on back of certificates.

D77665

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77665

CERTIFICATE OF DEATH.

3 113

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 419 So. Bond St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard L. Pierce

(Residence in Baltimore: No. 419 So. Bond St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Oct. (Month) 26 (Day) 1922 (Year)

7-AGE. 0 yrs. 8 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md

PARENTS.

10-NAME OF FATHER, Wm Pierce

11-BIRTHPLACE OF FATHER, (State or Country), Md

12-MAIDEN NAME OF MOTHER, Mary Squires

13-BIRTHPLACE OF MOTHER, (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Pierce

(Address) 419 So. Bond St

15- Filed JUL 21 1923 192.... Registrar.

Robert P. Harrison,
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 19th (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Enter-Colitis

(Duration) 0 yrs. 0 mos. 1 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Thos. P. Horton M. D.
Coroner.

July 19th 1923 (Address) Curtis Bay, Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel Cem. DATE OF BURIAL, July 21 1923

20-UNDERTAKER, L. Sander Sons ADDRESS 1710 Pratt

N.B.—Every item of information should be carefully supplied. Exact statement of occupation may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificate. This information is very important.

JUL 21 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77666 ✓ D77666

CERTIFICATE OF DEATH.

73

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE (No. 700 Cathedral St., 11 WARD)

2-FULL NAME Luther Whitmore Shipley

(a) RESIDENCE NO. 700 Cathedral St., 11 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Belle Shipley

6 DATE OF BIRTH (month, day, and year) May 24/1855

7 AGE	Years	Months	Days	If UNDER 1 day, ... hrs. or ..... min.
	67	1	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Travelling Salesman over
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS
10 NAME OF FATHER Caleb Shipley
11 BIRTHPLACE OF FATHER (city or town) (State or country) Md
12 MAIDEN NAME OF MOTHER Ara Hobbs
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Ida Belle Shipley
(Address) 700 Cathedral St

15 Filed JUL 21 1923, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1923

17 I HEREBY CERTIFY, That I attended deceased from June 16th, 1923, to July 18, 1923, that I last saw him alive on July 18th, 1923, and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:
Paralysis Ingluvies

(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Inanition, secondary, about (duration) — yrs. 8 mos. / ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Norbert Street M. D.

, 19 (Address) 712 Park Ave, Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Neudrec-Howard Co	July 21, 1923
20 UNDERTAKER Wm Hickman & Sons	ADDRESS North & Pa

NOTE—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D77667

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77667

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 623 N. Linwood Ave. WARD) 7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margarette Loretta Lowe.

(a) RESIDENCE No. 623 N. Linwood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John W.P. Lowe.

6 DATE OF BIRTH (month, day, and year) March 22nd 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	63	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Frederick
(State or country) Md.

PARENTS

10 NAME OF FATHER George W. Lindrow

11 BIRTHPLACE OF FATHER (city or town) Harpers Ferry
(State or country) W. Va.

12 MAIDEN NAME OF MOTHER Margarette Cromwell

13 BIRTHPLACE OF MOTHER (city or town) Frederick
(State or country) Md.

14 Informant John W.P. Lowe
(Address) 623 N. Linwood Ave.

15 Filed JUL 21 1923, 19 Robert P. Harrison,
Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19th 1923

17 I HEREBY CERTIFY, That I attended deceased from April 25th, 1923, to June 19th, 1923.

That I last saw her alive on June 19th, 1923,

and that death occurred, on the date stated above, at 4.50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of —

Was there an autopsy? No

What test confirmed diagnosis? Xray.

(Signed) Geo. W. Thurgate Dow M. D.

(Address) 401 E. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	July 21 1923

20 UNDERTAKER Burkler & Burkler — ADDRESS 1739 Eager

N. B.—WRITE LEGIBLY. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77668

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001 D77668

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 745 Vine St ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecilia Holly - (HOLLY)

(a) RESIDENCE NO. 745 Vine St ST., ... WARD 4

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Blk	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Holly

6 DATE OF BIRTH (month, day, and year) Mch 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
49	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) St Marys County Md

PARENTS

10 NAME OF FATHER Jeff Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys County Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co Md

14 Informant Mabel Jones (Address) 739 Vine St

15 Filed ..... 19 ..... Registrar Robert P. Harrison,

JUL 21 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/19 1923

17

I HEREBY CERTIFY, That I attended deceased from July 19 ..... 1923 ... to July 19th 1923.

that I last saw her alive on July 19 1923.

and that death occurred, on the date stated above, at 10.08P m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. 2 mos 2 ds.

CONTRIBUTORY (Secondary) Perforation

(duration) yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? ..... East Bay

Did an operation precede death? No ... Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Smear

(Signed) Gustav Goldman, M. D.

, 19 (Address) 656 N Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	7/23 1923
20 UNDERTAKER Samuel Hamburger	ADDRESS 17 N Bond

N. B.—WRITE PLAINLY. All items should be carefully supplied. Age should be stated in years, months and days. Exact statement of OCCUPATION should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

H.L.H. 5 D77669

HEALTH DEPARTMENT—CITY OF BALTIMORE

5 Am. 16-0 D77669

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 5

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 5 WARD)

2-FULL NAME Tony Cuciatti.

(a) RESIDENCE NO. 411 N. Front St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. unknown mos. ds. · How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/12/1923

7 AGE — Years: — Months: 5 — Days: — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of Industry, business, or establishment in which employed (or employer): Balto Md

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) —

PARENTS

10 NAME OF FATHER Peter Cuciatti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Josephine Pippins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed ..... 19 ..... Registrar

JL 21 1923

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1923 to July 19, 1923.

that I last saw him alive on July 19, 1923,

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Acute bacillary dysentery

(duration) 0 yrs. 0 mos 10 ds.

CONTRIBUTORY (Secondary) Acute bacillary dysentery

(duration) 0 yrs. 0 mos. 10 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Character of stools

(Signed) William H. F. Wartheu, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemtery — DATE OF BURIAL: 7/21 1923

20 UNDERTAKER: George J Ruth — ADDRESS: 1735 Hanford Av

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77670

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D77670

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1224 Penna Ave. ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arena Carpenter

(a) RESIDENCE No. 1224 Penna. Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: Colord

5 ~~Single~~, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of: Rufus Carpinter

6 DATE OF BIRTH (month, day, and year):

7 AGE: 59 Years — Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): md

PARENTS

10 NAME OF FATHER: William H. Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): dd

12 MAIDEN NAME OF MOTHER: Emely Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Harry Carpenter

(Address): 1224 Eagle Ave

15 Filed JUL 21 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1923, to July 18th, 1923, that I last saw her alive on July 18th. 1923, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Broken Compensation
Cardiac

(duration) yrs. mos. 20ds.

CONTRIBUTORY (Secondary) Mitral Ins.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? no. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam

(Signed) Walter G. Jackson, M. D.

, 19 (Address) 1618 W. Mulberry St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: July 21 1923

20 UNDERTAKER: John H. Goodwin — ADDRESS: 1424 Hill

AGE should be stated EXACTLY. Information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E.—WRITE CLEARLY so that it may be properly classified.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77671

CERTIFICATE OF DEATH.

31 D77671

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 Myrtle Av ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorenzo Payne

(a) RESIDENCE NO. 1310 Myrtle Av ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 5 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Beatrice Payne

6 DATE OF BIRTH (month, day, and year) Nov 9th 902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	21 yrs	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of Industry, business, or establishment in which employed (or employer) Piano Player

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER James H. Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Bertie L Garrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Bertie L. Payne
(Address) 1310 Myrtle Av

15 Filed ..... 19 .....
Registrar

Robert F. Garrison,
JUL 21 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18th 1923

17

I HEREBY CERTIFY, That I attended deceased from March 14th, 1923, to July 18, 1923, that I last saw him alive on July 16th, 1923, and that death occurred, on the date stated above, at 5:55 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (duration) — yrs. 8 mos — ds.

CONTRIBUTORY (Secondary) Pleurisy & Gastritis (duration) yrs 2 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination of Sputum

(Signed) Edward E. Mackenzie, M. D.

July 9th, 1923 (Address) 1339 N North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	July 21 1923

20 UNDERTAKER John H Toadvine ADDRESS 142 Carlton St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77672

CERTIFICATE OF DEATH.

90 D77672

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Schnapp.

(a) RESIDENCE. NO. Mt Hope Retreat ST. 28 WARD. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred abt 26 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 57 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) About 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
abt	57	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber.

(b) General nature of industry, business, or establishment in which employed (or employer) Barbering (?)

(c) Name of employer

9 BIRTHPLACE (city or town) (?) (State or country) Maryland

PARENTS

10 NAME OF FATHER (?) Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) "

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Records of Mt Hope (Address) Mt Hope Md.

15 Filed . 19 Robert F. Harrison Registrar

JUL 21 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 25 1897 to July 20th 1923, that I last saw him alive on July 20th 1923, and that death occurred, on the date stated above, at 11:45 A. m.

The CAUSE OF DEATH* was as follows:

Acute Dilitation of Heart.

abt (duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) Paranoiac Psychosis abt (duration) 26 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Dr

(Signed) Frank J. Flannery, M. D.

July 20, 1923 (Address) Mt Hope Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemy. DATE OF BURIAL: July 21/1923

20 UNDERTAKER: STEWART & MOWEN COMPANY ADDRESS: 108 W. North Ave.

Information should be carefully supplied. AGE should be stated in last birthday. Exact statement of OCCUPATION is necessary so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77673

CERTIFICATE OF DEATH.

21 D77673

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 Montgomery ST.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sadie Footes

(Residence in Baltimore: No. 502 Montgomery St.; .....yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, un Known ....., 1905
(Month) (Day) (Year)

7-AGE, 18 yrs. — mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Thos I. Footes

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Maggie Curry

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Footes

(Address) 502 Montgomery

15- Filed JUL 21 1923, 191.....

Robert P. Harrison, Registrar.
Burial Permit Clerk.

JUL 21 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 19, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 1 1923, to July 19 1923, that I saw h[er] alive on July 16 1923, and that death occurred, on the date stated above, at 1[?] m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) H. C. M. Carr M. D.

July 20, 1923 (Address) 2005 Druid Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn Ct. DATE OF BURIAL, July 21, 1923

20-UNDERTAKER J. L. Brown & Son ADDRESS 1058 W. Monty St

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION is necessary that CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION is necessary that CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of information should be carefully supplied. Exact statement of OCCUPATION is necessary that CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION is necessary that CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of information should be carefully supplied. Exact statement of OCCUPATION is necessary that CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION is necessary that CAUSE OF DEATH in plain terms, so that it may be properly classified. Every item of information should be carefully supplied. Exact statement of OCCUPATION is necessary that CAUSE OF DEATH may be properly classified. Exact statement of OCCUPATION is necessary that CAUSE OF DEATH in plain terms, so that it may be important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D77674

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77674

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 W. Cross St. ST., 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Otis C. Carter. (C).

(a) RESIDENCE NO 532 W. Cross St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) March 23, 1907.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16	3	26.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Robert Carter. (C).

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Millie Randall. (C).

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia.

14 Informant Millie Carter. (C). (mother).
(Address) 532 W. Cross St.

15 Filed ..... 192 Robert F. Herrmann. Registrar

JUL 21 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

July 21, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Kent Co Va	July 21 1923
20 UNDERTAKER	**ADDRESS**
C. V. Brown's Son	108 W Mounds

Chas Heath Funeral Co for Burial in New Kent Co Va

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

D77675

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77675

CERTIFICATE OF DEATH.

Registered No. C. 9 1

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Smeton

(Residence in Baltimore: No. 32 S. Hare St. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	Single

6-DATE OF BIRTH. Feb 25 1922
(Month) (Day) (Year)

7-AGE. 1 yrs. 4 mos. 23 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Frank Smeton

11-BIRTHPLACE OF FATHER. (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Anna Junghaenel

13-BIRTHPLACE OF MOTHER. (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
Frank Smeton
(Informant)
23 S. Hare St.
(Address)

15- JUL 21 1923 Filed 192 Robert P. Harrison, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 20 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia
Autopsy at hospital
(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Whooping Cough
(Duration) 2 yrs. mos. ds.

(Signed) J. M. Dallam M. D.
(Coroner.)
July 21 23 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death. yrs. mos. ds. In the State. yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Holy Redeemer DATE OF BURIAL. July 21 1923

20-UNDERTAKER. Jos. J. Kerr & Son ADDRESS 156 W. Lanvale ave

Every item of information should be carefully supplied. Use ink. Do not write figures. Be sure that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D77676

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 D77676

1 PLACE OF DEATH — REGISTERED No. C

CITY OF BALTIMORE (No 14 E. Twenty Second St. St. 12 WARD) (If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John Hall

(Residence in Baltimore: No. 14 E 22nd St St. 52 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: November 9 1846 (Month), 1 (Day), (Year)

7 AGE: 76 yrs. 8 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Jeweler
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Cincinnati Ohio

PARENTS

10 NAME OF FATHER: John Hall

11 BIRTHPLACE OF FATHER (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Martha J. Wolton

13 BIRTHPLACE OF MOTHER (State or country): Ohio

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Hall

(Address) 14 E. 22nd. St

15.

Filed ..... 19[illegible] Robert P. Harrison, REGISTRAR

Burial Permit Clerk.

JUL 21 1923

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 19th (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6th, 1923, to, July 19th 1923, that I saw h[illegible] alive on July 17th, 1923, and that death occurred, on the date stated above, at 2.30 p m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(Duration) 3 yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Thomas L Sheare M. D.

July 20th, 1923 (Address) 705 N Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	7/21 1923

20 UNDERTAKER	ADDRESS
J. Frew McCully	130 E Fort

Spec—12-23-21—E.B.R.S.—400 Blks.

D77677

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77677

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 17 S Bond St. St., 3 Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME. Wm Henry Baumeister

(a) Residence No. 17 S Bond St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 2 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine

6-DATE OF BIRTH (month, day and year) May 11, 1853

7-AGE. 70 yrs. 2 mos. 8 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Manufacturer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. John Baumeister

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Margaret Haverkamp

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14- (Informant) Fred Wm H. Baumeister

(Address) 17 S. Bond St.

15- Filed ..... Registrar.

Robert P. Harrison, Registrar.

UL 21 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 19 - 23

17- I HEREBY CERTIFY, That I attended deceased from June, 1923, to July 19th, 1923, that I last saw him alive on July 19th, 1923, and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B. (Final)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Laboratory

(Signed) G. F. Ries, M. D.

July 20, 1923 (Address) 24 S. Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Holy Redeemer	July 23, 1923
20-UNDERTAKER.	ADDRESS
A Heerman	32 S Broadway

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77678

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77678

CERTIFICATE OF DEATH.

1823

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Domenica Gramigna

(Residence in Baltimore: No. 808 Stiles St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	Single

6-DATE OF BIRTH. Nov. (Month) 4 (Day) 1920 (Year)

7-AGE. 2 yrs. 8 mos. 8 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Giuseppe Gramigna

11-BIRTHPLACE OF FATHER, (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Felicetta Coscagna

13-BIRTHPLACE OF MOTHER, (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Giuseppe Gramigna

(Address) 808 Stiles st

15-

Filed JUL 21 1923, 192.....

Robert P. Harrison,
Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 18 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Wound Disp. Ulcer & Gun
Shot wound of abdomen —
accidental (Shot by another)
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

July 21 1923 (Address) 639 Lanv

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer DATE OF BURIAL, July 24 1923

20-UNDERTAKER, Geo. F. Roth ADDRESS 1735 Hark...

NOTE—Every item of information should be carefully ... state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

D77679

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hospital St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Dorsey

(Residence in Baltimore: No. Garsuch Ave. & Adams St. St.; yrs. 1 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	single

6-DATE OF BIRTH. ? (Month) ? (Day) ? (Year)

7-AGE. ..... yrs. 2 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: child
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER, foster Mrs. Emma Dorsey

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harriett O. Johnson

(Address) 313 Central Ave.

15- Filed JUL 21 1923 192.... Robert P. Harrison, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 20/23 (Month) (Day) (Year) 19..

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Diarrhea not Dysentery

(Autopsy at hospital)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos. J. Poteet M. D. (Coroner.)

7/21/23 192.... (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park — DATE OF BURIAL, July 21, 19 23

20-UNDERTAKER, William Cook — ADDRESS 502 E North

N.B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

113 D77679

Spec.—1-10-21—M&T—1500 Bks.

164831 D77680

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 D77680

REGISTERED NO.....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (NO. ..... ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ladie Burea.

(a) RESIDENCE NO. 1721 Clarkson St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. Unknown mos. ..... How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 28, 1913.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	9	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School.

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Grason Burea.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lucy White.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed JUL 21 1923 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1923

17 I HEREBY CERTIFY, That I attended deceased from July 2 1923 to July 20 1923, that I last saw her alive on July 20 1923, and that death occurred, on the date stated above, at 6 30 a. m.

The CAUSE OF DEATH* was as follows:

Acute rheumatic fever and chorea

(duration) 2 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Endocarditis pericarditis myocardial insufficiency

(duration) 0 yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical course of disease

(Signed) William H. F. Wartes, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL July 23 1923

20 UNDERTAKER John F Denny

ADDRESS 713 Light

N. B.—WRITE PLAINLY, with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77681

CERTIFICATE OF DEATH.

129 D77681

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1919 Gough St. ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Ditzel

(a) RESIDENCE NO. 1919 Gough St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Ditzel

6 DATE OF BIRTH (month, day, and year) March 15-1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	84	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER William Grosh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Conrad Ditzel (Address) 1919 Gough St.

15 Filed JUL 21 1923 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1923.

17 I HEREBY CERTIFY, That I attended deceased from July 12. 1923. to July 18. 1923.

that I last saw h[e]r alive on July 17. 1923.

and that death occurred, on the date stated above, at 8 P. m.

THE CAUSE OF DEATH* was as follows: Chronic nephritis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Dementia

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. H. Keller M. D.

(Address) 193 Gough St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL July 21 1923

20 UNDERTAKER Lilly and Zeiler ADDRESS 403 S. Nov Ave

N. B.—WRITE PLAINLY, WITH INK. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77682

D77682

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 400 Pinkney ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew J. Rutherford

(a) RESIDENCE. No. 400 Pinkney ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced (Write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 21 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	54	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Andrew Rutherford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Scotland

12 MAIDEN NAME OF MOTHER: Bridget King

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Annie Rutherford (Address) 400 Pinkney St

15 Filed JUL 21 1923, 19 Registrar Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1923

17 I HEREBY CERTIFY, That I attended deceased from April 19 1923, to July 19 1923,

that I last saw h[illegible] alive on July 19 1923,

and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH was as follows*: Diabetes

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical Symptoms

(Signed) John W. Mongotory M.D.

7/20/23 (Address) 401 E 25 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Presbyterian Cem	July 23 23
20 UNDERTAKER	ADDRESS
E. A. Wiedefeld Jr	501 E 22

A. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bkt.

7768 D7768

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77683

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., S WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Louise Weber

(a) RESIDENCE NO. Gambrills Maryland ST., WARD

((U)sual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (~~HUSBAND of~~) (or) WIFE of Rev. Wm Weber

6 DATE OF BIRTH (month, day, and year) Feb 24 1867

7 AGE — Years: 56 — Months: 4 — Days: 27 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Theodore Kebelob

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Marie Busemann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss Anne Weber

(Address) 837 Hollins St

15 Filed JUL 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-21 1923

17 I HEREBY CERTIFY, That I attended deceased from 7-19, 1923, to 7-21, 1923

that I last saw her alive on 7-21, 1923

and that death occurred, on the date stated above, at 11:15 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) Diabetes mellitus

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) R. A. Seyler M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: All Saints Chapel — DATE OF BURIAL: July 23 1923

20 UNDERTAKER: R. F. Williams — ADDRESS: Woodlawn Md.

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. Information should be carefully supplied. Exact statement of OCCUPATION should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77684

D77684

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 So. Bethel St ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Lyman.

(a) RESIDENCE NO. 104 So. Bethel ST., B WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE: 27 Years yrs. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harford County

PARENTS

10 NAME OF FATHER: Albert Gilbert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co.

12 MAIDEN NAME OF MOTHER: Mary Gilbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co,

14 Informant: Mary Gilbert

(Address) 104 S. Bethel St.

15 Filed JUL 22 1923, 19 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1923. to July 21, 1923.

that I last saw her alive on July 20, 1923,

and that death occurred, on the date stated above, at 6.45 A.m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lungs

Tuberculosis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Dr W W Kennard M. D.

7-21, 1923 Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury cemetery — DATE OF BURIAL: July 24 '23

20 UNDERTAKER: Joseph T. H. Rochester — ADDRESS: 1413 Pennsylvania Ave

N. B.—WRITE PLAINLY, WITH INDELIBLE PENCIL. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

165007 D77685

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77685

CERTIFICATE OF DEATH. 36-005

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Dominick Pantalacci

(a) RESIDENCE NO. 4008 Park Hts. Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown yr. How long in U. S., if of foreign birth? yrs. mos.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER Pierre

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Benoite Bettini

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed JUL 22 1923, 19..... ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1923 to July 21, 1923

that I last saw him alive on July 21, 1923

and that death occurred, on the date stated above, at 1.35 a. m.

The CAUSE OF DEATH* was as follows:

Acute hemorrhagic nephritis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) secondary hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Balto. Md

Did an operation precede death? yes Date of July 14

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Cecil H. Bagley, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL July 23, 19 23

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 N Bway

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS are required to report promptly to the Health Department all facts in their possession relative to each case of death. Information should be carefully supplied. AGE should be given in years, months and days. If LESS than one day, hours or minutes. CAUSE OF DEATH should be plainly stated, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Operation for removal of T.B. glands from axilla.

Spec.—1-10-21—M&T—1500 Bks.

165-148 D77686

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 90 D77686

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ..... ST. ..... WARD)

2-FULL NAME Charles Donnelly

(a) RESIDENCE NO. Rock Hall ST., ... WARD Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown 5 days. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER Charles O

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 22 1923, 19 ..... Registrar ROBERT R. KRAUTH Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1923. July 21, 1923.

that I last saw alive on July 21, 1923,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency acute

Stenosis-Aortic Insufficiency.

Relative mitral Insufficiency

(duration) 1 yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) V. H. Veeman, M. D.

7-21, 1923 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rock Hall Md — DATE OF BURIAL July 23 1923

20 UNDERTAKER Joseph Ahrens — ADDRESS 22 Bway

N. B.—WRITE PLAINLY, WITH INK. ALL INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77687 D77687 135

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. McCulloh & Biddle ST.;..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alexander Queen

(Residence in Baltimore: No. 566 Orchard St.; 17 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, ... (Month) Unknown (Day) ..... 1 (Year)

7-AGE, 68 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Porter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, — Queen,

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lula Queen

(Address) 566 Orchard St

15- Filed JUL 22 1923 ROBERT R. KRAUTH, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 17 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1923, to July 17 1923, that I saw h-im alive on July 15 1923, and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) 2 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Thrombosis

(Duration) 1/2 yrs. ..... mos. ..... ds.

(Signed) H. S. McCauley M. D.

7/22, 1923 (Address) 2005 O'Donnell

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, M. P. Br. Woodlawn Cem. DATE OF BURIAL, 7/22, 1923.

20-UNDERTAKER Samuel Hemsley ADDRESS 578 W Biddle St

Information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificate. DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

D77688

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77688

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2219 E. Biddle at ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella S. Chenoweth

(a) RESIDENCE NO. 2219 E. Biddle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If ~~married~~, widowed, or ~~divorced~~, HUSBAND of (or) WIFE of Daniel E. Chenoweth

6 DATE OF BIRTH (month, day, and year) Sept 24 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John W. Foy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Eliza Lancaster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Charles C. Strieb

(Address) 2219 E. Biddle

15 Filed JUL 22 1923, 19.... ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1923

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1923, to July 20, 1923, that I last saw her alive on July 20, 1923 and that death occurred, on the date stated above, at 10.[illegible] p m.

The CAUSE OF DEATH* was as follows:

Rheumatoid Arthritis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John S. Fenby, M. D.

7/24, 1923 (Address) 3522 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Baltimore Cemetery July 24 1923

20 UNDERTAKER — ADDRESS

Henry Lutz N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77689

CERTIFICATE OF DEATH.

124 D77689

REGISTERED NO.

1-PLACE OF DEATH Church Home & Infirmary

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Mrs. Nettie Scherer

(a) RESIDENCE NO. 1455 Broadway Balto. Md ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred not known. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state EXACTLY. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60 yrs.	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Husband (Jacob Scherer)

(Address) 1455 E. Broadway

15 Filed ..... 19 ..... Registrar

JUL 22 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1923

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1923, to July 22, 1923, that I last saw h alive on July 22, 1923, and that death occurred, on the date stated above, at 2:45 A m

The CAUSE OF DEATH* was as follows:

Empyema of Gall Bladder

(duration) yrs. 7 days mos — ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? Yes Date of July 20

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) E. C. Rice, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sylvan Lawn

DATE OF BURIAL: July 22 1923

20 UNDERTAKER: Jacob Lewis

ADDRESS: 1432 E. Baltimore

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77690 D77690

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH REGISTERED NO. C

CITY OF BALTIMORE: (No. 1733 E Baltimore St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie R. Mitnick

(Residence in Baltimore: No. 1733 E Baltimore St.; 31 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, April 14th, 1866 (Month) (Day) (Year)

7-AGE, 57 yrs. 3 mos. 5 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Moses Aaron Schneider

11-BIRTHPLACE OF FATHER (State or Country), Russia

12-MAIDEN NAME OF MOTHER Golda Rose Rodkin

13-BIRTHPLACE OF MOTHER (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Lewis

(Address) 1439 E. Balto. St.

15-

JUL 22 1923 ROBERT R. KRAUTER.

Filed....., 191.... Burial Permit Recorder.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 19th, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 21 1923, to July 19th 1923, that I saw h[er] alive on July 19 1923, and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolus

5 hours.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Thrombo Phlebitis, Pelvis

(Duration) yrs. 25 mos. ds.

(Signed) Jno. H. E. Lothian M. D.

July 20 1923 (Address) 1317 E. Madison St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship DATE OF BURIAL, July 22 1923

20-UNDERTAKER Jack Lewis ADDRESS 1439 E. Balto.

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(See affadavit over) Dr. Greenfield D77691

D77691

HEALTH DEPARTMENT—CITY OF BALTIMORE

1925

CERTIFICATE OF DEATH.

122-001 — 1848

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2571 Fulton Ave. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. J. Hoteck NO

(a) RESIDENCE NO. 2571 Fulton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Hoteck

6 DATE OF BIRTH (month, day, and year) May 27-1848 1862

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58 61.	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Electric Co

(c) Name of employer Machine Co

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Geo. P. Hoteck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Mary E. Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Mary E. Hoteck

(Address) 2571 Fulton Ave

15 Filed JUL 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1925

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1925, to July 20, 1925.

That I last saw h.... alive on July 20, 1925, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Arthrosis & Liver

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Asthma

(duration) — yrs. 5 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edw. Compton, M. D.

1925 (Address) 317 Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July 24 1925

20 UNDERTAKER J. B. Keppler ADDRESS 2336 Fulton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Balto. Md.
July. 24-1923

To. whom this may concern.

This is to certify that
Mrs. Mary E. Hobeck gave to me the incorrect age of
Mr. William T. Hobeck. The age on the death certif
showing that Mr. Hobeck is 58 yrs. Old.
This is incorrect, Mr. Hobecks correct age
should be May 27, 1862 - making him 61. yr. 1 mon

Yours. Truly.
Edw Grentzer
Undertaker

Witness.
J. H. Clopper.

I hereby certify that the above statement was made
Edw. Grentzer on this 24th day of July, that he sig
signed the above statement
James L. Clopper
Notary Public.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77692

CERTIFICATE OF DEATH.

47 ✓ D77692

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 321 Chafanoke Ave St.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Carrie P. Redifer.

(Residence in Baltimore: No. 321 Chafanoke Ave St.; ..... yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, June 16, 1878
(Month) (Day) (Year)

7-AGE, 45 yrs. 1 mos. 4 ds.

If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, David S Fowler

11-BIRTHPLACE OF FATHER (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Margaret Schafer

13-BIRTHPLACE OF MOTHER (State or Country), Balto. Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs C. Redifer

(Address) 321 Chafanoke Rd

15- Filed JUL 22 1923, 191.... ROBERT R. KRAUTER Registrar.
Burial Permit No. K.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 20, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Nov 21 1922, to June 20 1923, that I saw h[illegible] alive on June 20 1923 and that death occurred, on the date stated above, at 4.05 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast
(Duration) yrs. 6 (Seven 5) mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma (Recurrent metastasis) Operation
(Duration) yrs. 8 mos. ..... ds.

(Signed) C B Evans M. D.

7-20., 1923 (Address) 5016 Park Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge Cem — DATE OF BURIAL, July 23 1923

20-UNDERTAKER F. C. Krause & Son — ADDRESS 703 Hanover

N.B.—Every item of information should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Ball.

D77693

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D77693

1-PLACE OF DEATH 9.

REGISTERED NO. D77693

CITY OF BALTIMORE: (No. 227 Montford Ave. WARD) 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Ball

(a) RESIDENCE NO. 227 Montford Ave. WARD 6

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word)
femal	colored	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) chase md

PARENTS

10 NAME OF FATHER William Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) chase md

12 MAIDEN NAME OF MOTHER mary lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) chase md

14 Informant annie hammond

(Address) 227 W. montford av

15 Filed JUL 22 1923 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-18- 1923

17 I HEREBY CERTIFY, That I attended deceased from 4-20-, 1923, to 7-18-, 1923, that I last saw h~~e~~r alive on 7-16-, 1923, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) indefinite yrs. mos ds.

CONTRIBUTORY (Secondary) Gangrene of foot

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed ~~diagnosis~~? no

(Signed) W. H. Hargis, M. D.

7-21-1923 (Address) 611-N-Carol

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chase md

DATE OF BURIAL July 22 1923

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans st

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

U.S. AFI

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77694

CERTIFICATE OF DEATH.

D77694

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1209 Edward St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Madline Goldstone

(a) RESIDENCE. No. 1616 E Monument St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto city
(State or country)

PARENTS

10 NAME OF FATHER Oscar Goldstone

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Thompson

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Margaret Thompson
(Address) 1616 E monument St

15 Filed JUL 22 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1923, to July 20, 1923, that I last saw h.. alive on July 20, 1923, and that death occurred, on the date stated above, at 9.15 P m.

The CAUSE OF DEATH* was as follows:

Whooping cough

(duration) yrs. mos. 5 ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1616 E monument St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H Edward Fisher, M. D.

7-21, 19-23 (Address) 1612 E monument St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July 23 1923
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans St

NOTE.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION should be given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

BALTIMORE CITY ARCHIVES

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77695

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31: D77695

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 E Biddle ST.; WARD)

2-FULL NAME Robt H Eccleston

(a) RESIDENCE. No. 702 E Biddle ST., 10 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26 1888

7 AGE: Years 35 | Months | Days 24 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): A. P.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Robert E. Eccleston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co. Balto

12 MAIDEN NAME OF MOTHER: Mary E Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto City

14 Informant: Florence Eccleston

(Address) 702 E Biddle St

15 Filed JUL 22 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-20 1923.

17 I HEREBY CERTIFY, That I attended deceased from Dec 21, 1921, to 7-20, 1923

that I last saw him alive on 7-20, 1923

and that death occurred, on the date stated above, at 8 15 A m.

The CAUSE OF DEATH* was as follows:

Myocardia Insufficiency

CONTRIBUTORY (Secondary) (duration) 3 yrs. mos. ds.

Pulmonary T B (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum X Ray

(Signed) Deaderick M. D.

, 19 (Address) 1506 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park DATE OF BURIAL: July 23 1923

20 UNDERTAKER: John M Weber ADDRESS: 1803 Bank St

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77696

CERTIFICATE OF DEATH.

90 D77696

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 Hanover St. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa J. Wyvill.

(a) RESIDENCE NO. 509 Hanover St. ST., W WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Marmaduke Wyvill.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Ellen Coe.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Louisa R. Weatherley. (Address) 5000 York Road.

15 Filed ..., 192... ROBERT R. KRAUTER Registrar

JUL 22 1923

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21st, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart.

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto Reinhardt M. D. (Coroner)

July 21, 1923. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Interred	Jul 23 1923
20 UNDERTAKER	ADDRESS
J. C. Trainum & Bro.	1 + Bremen Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

16447 D77697

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00 D77697

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 920 N Mount ST., WARD)

2-FULL NAME Freddie Dupspins

(a) RESIDENCE NO. 920 N. Vincent St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mch. 7-22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	1	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Lewis Dupspins

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Downs

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed JUL 22 1923 19 ROBERT R. KRAUTH Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1923

17 I HEREBY CERTIFY, That I attended deceased from June 16 - 1923 to July 21 - 1923.

that I last saw h alive on July 21 - 1923,

and that death occurred, on the date stated above, at 3 30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. 1 mos 5 ds.

CONTRIBUTORY (Secondary) Acute otitis media

(duration) — yrs. — mos. 14 ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? Yes —

What test confirmed diagnosis? None.

(Signed) Horton Caspars, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL July 23 1923

20 UNDERTAKER Clarence E. Wright — ADDRESS 1534 W Cary

Spec.—1-10-21—M&T—1500 Blks.

D77698

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77698

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 E. 25th St. ST., WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Dennis Pope

(a) RESIDENCE NO. 417 E. 25th St ST., 1 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 19-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	48	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) American Telephone

(c) Name of employer Telegraph Co. Cecil Co.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Wm. M. Bryall

(Address) 417 E. 25th St.

15 Filed JUL 22 1923, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1923

17 I HEREBY CERTIFY, That I attended deceased from 6/23, 19 23, to 7/18, 19 23

that I last saw h— alive on 7/18, 19 23,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yr. 4 mos ds.

CONTRIBUTORY (Secondary) Dec. Cardiac Nephritis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry F. Covey, M. D.

, 19 (Address) 1 Wesboro Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Grund Ridge	July 23 1923

20 UNDERTAKER Horace H. Burgee ADDRESS 163 Hall St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BATH EMBRACES RECORD, STATISTICAL AND MEDICAL. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

165135 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77699 CERTIFICATE OF DEATH. X 159-001 D77699

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., ... WARD)

2-FULL NAME Baby Phipps, (Vivian)

(a) RESIDENCE NO. La Grange N.C ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 17 ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 16-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) La Grange N.C

PARENTS

10 NAME OF FATHER Sarkin Phipps

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Car.

12 MAIDEN NAME OF MOTHER Effie Suggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed JUL 22 1923, 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1923

17

I HEREBY CERTIFY, That I attended deceased from July 16, 1923, to July 21, 1923, that I last saw h[illegible] alive on July 21, 1923, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus,

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? La Grange NC

Did an operation precede death? Yes Date of July 21-1923

Was there an autopsy? Yes

What test confirmed diagnosis? -

(Signed) Warfield M Firor, M. D.

7/21, 1923 (Address) Johns Hopkins Univ

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL La Grange N. C. — DATE OF BURIAL July 23 1923

20 UNDERTAKER Joseph Abrems — ADDRESS 22 Bury

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77700 ✓ 57 D77700

CERTIFICATE OF DEATH.

REGISTERED NO. —

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 204 N. Carrollton Ave (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Elizabeth Smith.

(a) RESIDENCE. No. 204 N. Carrollton Ave St. Ward.

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) WIFE of Francis M. Smith.

6 DATE OF BIRTH (month, day, and year) March 24 = 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
—	78	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER Henry Nicholson

11 BIRTHPLACE OF FATHER (city or town) (State or country) B

12 MAIDEN NAME OF MOTHER Mary Eliza Beck

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

✓ PARENTS

14 Informant George C. Shannon

(Address) 700 Fulton Ave

15 Filed JUL 22 1923 . 19 ROBERT R. KRAMES Registrar

Central Permit Office

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1923

17 I HEREBY CERTIFY, That I attended deceased from July 16 . 1923 . to July 22 . 1923.

that I last saw h~~er~~ alive on July 21 . 1923.

and that death occurred, on the date stated above, at 2.10 a m.

The CAUSE OF DEATH* was as follows:

Coma

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus.

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of None

Was there an autopsy? No.

What test confirmed diagnosis? Usual -

(Signed) George C. Shannon, M. D.

. 19 (Address) 700 Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 24 1923

20 UNDERTAKER John O. Mitchell ADDRESS 1211 W. Fayette

THIS IS A LEGAL DOCUMENT—PHYSICIANS should state AGE should be carefully supplied. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77701

CERTIFICATE OF DEATH.

45 D77701

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1073 W. Fayette St., ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Gerstmyer

(a) RESIDENCE NO. 1073 W. Fayette ST., 18 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be answered. Every statement of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Hush Gerstmyer

6 DATE OF BIRTH (month, day, and year) July 18, 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	=	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Selfin & Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER Louis Gerstmyer

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Sophia Bellstein

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Mary Gerstmyer (Address) 1073 W. Fayette St.

15 Filed JUL 22 1923 Registrar ROBERT R. KRAUS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1, 1922 to July 21, 1923, that I last saw him alive on July 21, 1923, and that death occurred, on the date stated above, at 8.40 m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Carcinoma rectum. Pleural Carcinomatosis (duration) 1 yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Cyrus T. Younge, M. D.

, 19 (Address) 817 Park ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL July 23 1923

20 UNDERTAKER, John O. Mitchell ADDRESS 1201 W. Fayette

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77702

CERTIFICATE OF DEATH.

129 D77702

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2338 Madison ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Dashiell

(a) Residence No. 2338 Madison ave St., 14 Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write this word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) Feb 9 1855

7-AGE, 66 yrs. 5 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER Dr N. L. Dashiell

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER Laura J. Wright

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Dr. N. L. Dashiell

(Address) 2927 St Paul St.

15- Filed JUL 22 1923 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 20 23

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 1923 to July 20 1923, that I last saw him alive on July 20 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Brights disease

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Unknown

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) N. L. Dashiell, M. D.

, 19 (Address) 2927 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Greenmount DATE OF BURIAL, July 23 19 23

20-UNDERTAKER, John O'Mitchell ADDRESS 1201 N. Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77703

CERTIFICATE OF DEATH.

100-001

D77703

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2727 N. Charles ST., WARD)

2-FULL NAME Samuel Martin Bayless

(a) RESIDENCE No 2727 N. Charles ST., 17 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 27 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harford Co Md

PARENTS

10 NAME OF FATHER: Wm. F. Bayless

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co Md.

12 MAIDEN NAME OF MOTHER: Eleanor Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: John L. Bayless Jr.

(Address): 2727 N. Charles St.

15 Filed JUL 22 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1923, to July 20, 1923,

that I last saw him alive on July 21, 1923,

and that death occurred, on the date stated above, at 3.15 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) Many years ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) J. Swann Bruchen M. D.

(Address) 806 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harmony Harford Co. DATE OF BURIAL: July 23 1923

20 UNDERTAKER: John O. Mitchell ADDRESS: 1201 N. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PAPER MUST NOT BE FOLDED. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

16508 D77704 — CERTIFICATE OF DEATH. — 16-002 — D77704

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Daniel Weinberg.

(a) RESIDENCE NO. 29 N. Patterson Park Ave. ST., 6 WARD
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. unknown How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 13 1922

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
1	4	10	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Harry Weinberg.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania.

12 MAIDEN NAME OF MOTHER Rose Goldfinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed JUL 22 1923, 19 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 19 23

17 I HEREBY CERTIFY, That I attended deceased from July 13, 19 23 to July 22, 19 23.
that I last saw him alive on July 22, 19 23
and that death occurred, on the date stated above, at 6.40 A. m.

The CAUSE OF DEATH* was as follows:

Dysentery (Flexner).

(duration) yrs. mos 12 ds.

CONTRIBUTORY —
(Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological.

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairview Rosedale

UNDERTAKER E. Levinson & Bro

DATE OF BURIAL 7/22 19 23

ADDRESS 1167 E. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic volvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Bacillary.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77705

CERTIFICATE OF DEATH.

49 D77705

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST., WARD)

2-FULL NAME Mrs Margaret Meyers

(a) RESIDENCE NO. 14 S Carey St ST. St Josephs Hospital WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) Jan 7 1856

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
67	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER Wm Wallenwein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant George F Myers

(Address) 14 S Carey St

15 Filed JUL 22 1923 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1923

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1923 to July 20, 1923.

that I last saw h[illegible] alive on July 20 1923

and that death occurred, on the date stated above, at 6:15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Head of Pancreas

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Yes Date of June 27, 1923

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Thorwood Nilson M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 23, 23
20 UNDERTAKER M Zink Son	ADDRESS 811 N Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

165156
D77706

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 159-001 D77706

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Elezabeth Geanoues

(a) RESIDENCE NO. 176 N Madeira ST., Winchester Va WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) June 6-22

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	1	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Winchester Va

PARENTS

10 NAME OF FATHER Pete Geanoues

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Villa Lemonis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va Va

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUL 22 1923 ROBERT R. KRAMER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1923, to July 21, 1923, that I last saw her alive on July 21, 1923, and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

1 Hydrocephalus

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Va

Did an operation precede death? No Date July 21-23

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Warfield M Theobald, M. D.

(Address) Winchester Va

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Winchester Va — DATE OF BURIAL 7/22 23

20 UNDERTAKER Geo J Smith — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Didzonoit

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77707

CERTIFICATE OF DEATH.

43 D77707

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 638 N. Franklin WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Wm Didzonoit

(a) RESIDENCE NO. 638 N. Franklin ST., 17 WARD
(Usual place of abode)
Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Didzonoit

6 DATE OF BIRTH (month, day, and year) Feb. 8-1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Self.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant V. E. Lynn.
(Address) 638 N. Franklin

15 Filed OCT 22 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 7 1923 to July 21 1923.

that I last saw him alive on July 21 1923.

and that death occurred, on the date stated above, at 9.15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Tongue

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) Frank E. Wagner M. D.

7/22, 1923 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emanuel Cemetery — DATE OF BURIAL July 23, 23

20 UNDERTAKER Wm Cook — ADDRESS 562 E. Lord

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77708

CERTIFICATE OF DEATH.

D77708

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home and Infirmary

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Robert Copper

(a) RESIDENCE No. Chestertown, Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of
x

6 DATE OF BIRTH (month, day, and year) Apl. 23, 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	17	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At school

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Kent Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Jesse R. Copper

11 BIRTHPLACE OF FATHER (city or town) Kent, Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER M.M. Calder

13 BIRTHPLACE OF MOTHER (city or town) Kent Co.
(State or country) Maryland

14 Informant Jesse R. Copper
(Address) Chestertown, Md

15 Filed JUL 22 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1923

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1923, to July 22, 1923, that I last saw h[illegible] alive on July 22, 1923, and that death occurred, on the date stated above, at 3:35 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of July 18, 1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical Methods

(Signed) Gaetano Bartolere, M. D.

, 19 (Address) Church Home and Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chestertown, Md	7-22-23 19
20 UNDERTAKER	ADDRESS
H.E. Hughes	424 N. Broadway

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Scratch on arm which occurred in Chestertown

Spec.—1-10-21—M&T—1500 Bks.

√77709

164916. D77709

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 90 D77709

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. ..... ST., ... WARD)

2-FULL NAME John Shinn

(a) RESIDENCE NO. 335 W. Third St ,ST., Wenton, W. Va. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 16 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Shinn wife.

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass Cutter.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Albert Shinn

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Rosetta Boyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed JUL 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1923

17

I HEREBY CERTIFY, That I attended deceased from July 6 1923 to July 22 1923 that I last saw him alive on July 22 1923 and that death occurred, on the date stated above, at 11.50 a. m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

(duration) ? yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) ..... yrs. 6 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? No especial test

(Signed) Hetherington ..... M. D.

7-22 1923 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pittsburg Pa	July 22 1923
20 UNDERTAKER	ADDRESS
Joseph Ahrens	221 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77710

HEALTH DEPARTMENT—CITY OF BALTIMORE

16-175 D77710

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Melvin J. Gera

(a) RESIDENCE NO. 4923 Dennone Ave. WARD 4

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 29-22

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work baby

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER John Gera

11 BIRTHPLACE OF FATHER (city or town) Hungary
(State or country)

12 MAIDEN NAME OF MOTHER Marie Talbio

13 BIRTHPLACE OF MOTHER (city or town) Hungary
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 Filed JUL 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1923 to July 21, 1923

that I last saw him alive on July 21, 1923

and that death occurred, on the date stated above, at 3 35 a.m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (Not Dysentery)

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Otitis Media

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Nose

(Signed) Horton Caspare, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL MOUNT OLIVET CEM

DATE OF BURIAL 7/23 1923

20 UNDERTAKER ROBERT BROOKS SON

ADDRESS CALHOUN HOLLINS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77711

CERTIFICATE OF DEATH.

74-001 D77711

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1710 Clendon ST., 23 WARD)

2-FULL NAME Wm J. Fahey

(a) RESIDENCE NO. 1710 Clendon ST., 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Fahey

6 DATE OF BIRTH (month, day, and year) Aug 14 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	65	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 140

(c) Name of employer

9 BIRTHPLACE (city or town) Bolton (State or country) Md

PARENTS

10 NAME OF FATHER James Fahey

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country) Ire

12 MAIDEN NAME OF MOTHER Catherine Burns

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant Mrs C. Bartes (Address) 1710 Clendon St.

15 Filed JUL 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to July 20, 1923, that I last saw h alive on July 20, 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Hypertension (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. Campbell M. D.

(Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bannie Brooks — DATE OF BURIAL 7/22/1923

20 UNDERTAKER J. F. Fahey & Sons — ADDRESS 318 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

1923
56
7 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77712

CERTIFICATE OF DEATH.

7H-001 D77712

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416-E Chase ST., WARD) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Francis Sullivan

(a) RESIDENCE No. 416 E. Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 8 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine B. Sullivan

6 DATE OF BIRTH (month, day, and year) Nov 14 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
56	—	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer) B+O R.R Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John F. Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Emma Lasch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Cath. B. Sullivan (Address) 416—E Chase

15 Filed. JUL 23 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct, 1921, to July 19th, 1923, that I last saw him alive on July 19, 1923, and that death occurred, on the date stated above, at 11 20 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Paralysis

(Signed) Gustav Goldman, M. D.

, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	7/23/1923
20 UNDERTAKER	ADDRESS
J J Fahey & Sons	1318 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77713

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77713

CERTIFICATE OF DEATH. C- 609462

1-PLACE OF DEATH U.S. Veterans' Hospital #56

REGISTERED NO.

CITY OF BALTIMORE: (No. Fort McHenry, Maryland ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Slaughter, George

(a) RESIDENCE NO. 233 Henrietta St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery Deliverer

(b) General nature of industry, business, or establishment in which employed (or employer) --

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Hospital records

(Address) Fort McHenry, Md

15 Filed JUL 23 1923 19 ROBERT E. KRANTZ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 19 23

17 I HEREBY CERTIFY, That I attended deceased from June 30, 19 23, to July 18, 19 23, that I last saw him alive on July 18, 19 23, and that death occurred, on the date stated above, at 8.15 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis, active

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? positive sputum

(Signed) H.W. Barker, Surgeon, R M. D.

Medical Officer in Temp. Charge.

7-18-23. 19 (Address) Ft. McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National U. S. C. | DATE OF BURIAL July 23 1923

20 UNDERTAKER L. V. Brown & Son | ADDRESS 108 W. Monument

Spec.—1-10-21—M&T—1500 Bks.

Pardo A. Corvinelli

D77714

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77714

CERTIFICATE OF DEATH.

44

REGISTERED NO.

1-PLACE OF DEATH at Home

CITY OF BALTIMORE: (No. 2513 Lauretta Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pardo Antonio Corvinelli

(a) RESIDENCE No. 2513 Lauretta Ave ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Carolina Pacchioneo

6 DATE OF BIRTH (month, day, and year) May 26 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lazino (Italy)

PARENTS

10 NAME OF FATHER Vincenzo

11 BIRTHPLACE OF FATHER (city or town) Lazino (State or country) Italy

12 MAIDEN NAME OF MOTHER Teresa Frezza

13 BIRTHPLACE OF MOTHER (city or town) Lazino (State or country) Italy

14 Informant Carolina Pacchioneo (Address) 2513 Lauretta Ave

15 Filed JUL 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 3 , 1923 , to July 20th 1923.

that I last saw him alive on July 20th , 1923,

and that death occurred, on the date stated above, at 8h 30' p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) 1 yrs. 4 mos 20 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinically

(Signed) Dr. Vincent Culotta M. D.

, 19 (Address) 811 Scott St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 7/23 1923

20 UNDERTAKER George J Ruth

ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Susie Taylor

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77715

CERTIFICATE OF DEATH.

31

D77715

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 834 Edmondson ST., 17th WARD)

2-FULL NAME Susie Taylor

(a) RESIDENCE NO. 834 Edmondson Ave WARD 17

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: B. F. Taylor

6 DATE OF BIRTH (month, day, and year): 1874

7 AGE: Years 49 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: James Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Louis Bush

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: B. F. Taylor

(Address) 834 Edmondson Ave

15 Filed JUL 23 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1923

17 I HEREBY CERTIFY, that I attended deceased from June 6th, 1923 to July 20th 1923.

that I last saw h— alive on July 20th 1923.

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 1 mos 1 ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Died home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

(Address) 1708 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Labor Cemetery Md | DATE OF BURIAL July 23 1923

20 UNDERTAKER: Frost A Gibson | ADDRESS S-13 Lanvale St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77716

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77716

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 528 W Conway ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Concetta Liberti

(a) RESIDENCE No. 528 W. Conway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 8 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Liberti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Foame

13 BIRTHPLACE OF MOTHER (city or town) (State or country) America (Balto)

14 Informant ~~Concetta~~ Joseph Liberti

(Address) 528 W. Conway St.

15 Filed JUL 23 1923 19 ROBERT R. KRAUTER, Registrar

~~Burial Permit Issued~~

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1923, to July 21, 1923,

that I last saw her alive on July 21, 1923,

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 528 Conway St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History + findings

(Signed) Damian Palay M. D.

, 19 (Address) 3326 Fredericus Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem.

DATE OF BURIAL July 23 1923

20 UNDERTAKER Mc Mus. J. W. Teufel & Son

ADDRESS 801 N. Fayette

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D7771?

CERTIFICATE OF DEATH.

74-001

D7771?

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 743 George ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Robinson

(a) RESIDENCE NO. 743 George ST., 17 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Blk	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susie Robinson

6 DATE OF BIRTH (month, day, and year) June 1874

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
49	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer P. J. McAvoy

9 BIRTHPLACE (city or town) Vicksburg (State or country) Miss

PARENTS

10 NAME OF FATHER Harry Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Annie Taylor (Address) 746 George

15 Filed JUL 23 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1923

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1923, to July 20, 1923.

that I last saw him alive on July 20, 1923.

and that death occurred, on the date stated above at 810 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Gustav Goldmann, M. D.

, 19 (Address) 656 N Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 7/23 1923

20 UNDERTAKER Samuel Hensley — ADDRESS 878 N Bdle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77718-51

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77718

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hospital.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Lilian McGruder

(a) RESIDENCE NO. 1306 Ettin ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Aug 27-1922

7 AGE Years ..... Months 10 Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work baby

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ?

PARENTS

10 NAME OF FATHER Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Fannie Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed JUL 23 1923, 19 ..... ROBERT R. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1923, to July 21, 1923, that I last saw her alive on July 21, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) — yrs. — mos 7 ds.

CONTRIBUTORY (Secondary) Acute otitis media secondary assumed

(duration) — yrs. — mos. 6 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Horton Cabaniss, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem

DATE OF BURIAL 7/23 1923

20 UNDERTAKER Samuel S Hemsley

ADDRESS 578 N Bdle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Matthew Byrnes

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77719

CERTIFICATE OF DEATH.

29

REGISTERED No. D77719

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. City Hospital - Bay View ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mathue Byrnes

(a) RESIDENCE NO. 1407 Eastern Ave ST., WARD 3

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Barbara Tickol

6 DATE OF BIRTH (month, day, and year) Feb-12-1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ..min.
	44	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City of Baltimore.

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records.

(Address)

15 JUL 23 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1923

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1923, to July 20, 1923.

that I last saw him alive on July 20, 1923.

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Tetanus

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Tetanus.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? While working

Did an operation precede death? Yes. Date of July 18, 23

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Wm. J. Fulton, M. D.

, 19 (Address) City Hospital. Bay View.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 24, 1923
20 UNDERTAKER	ADDRESS
Wm C. Miller	2334 Jefferson 24

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77720

CERTIFICATE OF DEATH.

91-002

REGISTERED No. C D77720

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 W. Redwood St ST.; 4 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Owen Curry

(Residence in Baltimore: No. 618 W. Redwood St.

St.: ~~70 yrs., 10 mos. 4 dys.~~ 8 yrs 10 mo 4 d.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, Sept. 25, 1852 (Month) (Day) (Year)

7-AGE, 70 yrs. 10 mos. 4 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Ireland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cora Curry (Wife)

(Address) 618 W. Redwood St

15- JUL 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 21, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 20 1923, to July 21 1923, that I saw him alive on July 21 1923, and that death occurred, on the date stated above, at 8:20 P. m.

The CAUSE OF DEATH* was as follows:

Uremic Coma

(Duration) 0 yrs. 0 mos. 3 ds.

CONTRIBUTORY (Secondary) General arterial sclerosis (Duration) 8 yrs. mos. ds.

(Signed) John C. Stansbury M. D.

July 22 1923 (Address) 1037 Edmondson Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Peters DATE OF BURIAL, July 23, 1923

20-UNDERTAKER John Fields ADDRESS 1001 W Fayette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D77721

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10 D77721 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 809 N. Dallas St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ANNIE BRISCOE

(Residence in Baltimore: No. 809 N. Dallas St.; yrs. 15 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	col	married

6-DATE OF BIRTH. unknown ....., 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
42 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). St. Mary's Co Md.

PARENTS.

10-NAME OF FATHER, Samuel Smoot

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Briscoe

(Address) 809 N. Dallas St.

15- Filed JUL 23 1923 19.. ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 22/23 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Endocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Diphtheria

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S H Cotton M. D. (Coroner)

7/23/23 (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Laurel Cemetery DATE OF BURIAL. July 23, 1923

20-UNDERTAKER. Mrs Robert A Elliott ADDRESS 1725 Ashland Ave

Spec.—1-10-21—M&T—1500 Blks.

D77722

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D77722

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 N. Monroe ST., WARD)

2-FULL NAME Baby Girl Thompson

(a) RESIDENCE NO. 719 N. Monroe ST., WARD 16

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 22 1923

7 AGE Years Months Days If LESS than 1 day hrs or min. 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cuba
(State or country)

PARENTS

10 NAME OF FATHER Sydney D. Thompson

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER Ruby Chambers

13 BIRTHPLACE OF MOTHER (city or town) England
(State or country)

14 Informant Sydney D. Thompson
(Address) 719 N. Monroe

15 JUL 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/23/1923

17 I HEREBY CERTIFY, That I attended deceased from 7/22/ .1923. to 7/23/ .1923.

that I last saw her alive on 7/23/23 .19

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard J. Tiery, M. D.

This 23 day of July 1923 (Address) 910 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loyola Cemetery DATE OF BURIAL July 23, 1923

20 UNDERTAKER Woodlawn Cem ADDRESS 2118 Edmondson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77723

CERTIFICATE OF DEATH.

161-00 D77723

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 N Monroe ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Thompson

(a) RESIDENCE NO. 719 N Monroe ST., 16 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
m	w	Sgl

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/22/23

7 AGE	Years	Months	Days	If LESS than 1 day, 7 hrs. or 23 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Sydney B. Thompson

11 BIRTHPLACE OF FATHER (city or town) Ga
(State or country)

12 MAIDEN NAME OF MOTHER Ruth B Cuba

13 BIRTHPLACE OF MOTHER (city or town) Jamaica, W.I.
(State or country)

14 Informant Sydney B Thompson
(Address) 719 N Monroe St

15 Filed JUL 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Recorder.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/22/23, 19

17

I HEREBY CERTIFY, That I attended deceased from 7/22/23, 19 , to 7/22/23, 19 ,

that I last saw h— alive on 7/22/23, 19 ,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Communicable Disease

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard J Fay, M. D.

July, 19 23 (Address) 4106 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem DATE OF BURIAL July 23 19 23

20 UNDERTAKER Geo W Lilly ADDRESS Edmondson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77724

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46

D77724

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 209 S Washington ST., 2 WARD)

2-FULL NAME Mary A. Collins

(a) RESIDENCE NO. 209 S. Washington ST., 2 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Joseph E. Collins

6 DATE OF BIRTH (month, day, and year) Feb 12th 1852

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
71	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER George Lanstee

11 BIRTHPLACE OF FATHER (city or town) Germany. (State or country)

12 MAIDEN NAME OF MOTHER Barbara Beck

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Edward Collins

(Address) 209 S. Washington St.

15 JUL 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22nd 1923

17 I HEREBY CERTIFY, That I attended deceased from May 17th, 1923, to July 21st, 1923, that I last saw her alive on July 21st, 1923 and that death occurred, on the date stated above, at 5 00 a. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Uterus

about 15 days (duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Heart arteriosclerosis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Bleeding, pain, [illegible]

(Signed) R. T. Hardy M. D.

, 19 (Address) 1202 N. Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 25 1923
20 UNDERTAKER Lilly & Geiler	ADDRESS 4005 Harford Ave

Spec.—1-10-21—M&T—1500 Bks.

Lib. 0277

D77725

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77725

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5417 Winner Ave WARD)

2-FULL NAME Margaret J. Henkle

(a) RESIDENCE NO. 5417 Winner St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if a foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced: (or) WIFE of Geo W. Henkle

6 DATE OF BIRTH (month, day, and year): Nov 18 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Emanuel Michael

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Geo W. Henkle

(Address): 5417 Winner

15 Filed ..... 19.... Registrar

JUL 23 1923 Social Service Bureau

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10 1923 to July 19 1923

that I last saw her alive on July 19 1923

and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. 2 mos 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Dr Young

(Signed) H. H. Hendrickson M. D.

19 (Address) 1711 E. Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western — DATE OF BURIAL: July 24 1923

20 UNDERTAKER: W R Cook — ADDRESS: 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

FILE COPY

ROBERT R. KRAUTER

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77726 D77726

CERTIFICATE OF DEATH.

90 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number (and fill out No. 18.)

2-FULL NAME James Dutton

(Residence in Baltimore: No. 1307 Linden Av St.; yrs.. mos.. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	white	Wid

6-DATE OF BIRTH.

..... 1..... (Month) (Day) (Year)

7-AGE. 62 abt yrs. mos. ds. If LESS than 1 day, ...hrs. or... min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Bath
(b) General nature of Industry, business, or establishment in which employed (or employer) Teacher

9-BIRTHPLACE. (State or Country). Balto Md

PARENTS

10-NAME OF FATHER. J W Dutton

11-BIRTHPLACE OF FATHER. (State or Country). Balto

12-MAIDEN NAME OF MOTHER. Annie M. Le Tourneau

13-BIRTHPLACE OF MOTHER. (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J W Dutton

(Address) 72(Druid Hill Ave Consulty

15- Filed JUL 23 1923 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 22 23 (Month) (Day) 192 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Arteriosclerosis

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary)

Duration yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

July 23 192 (Address) [illegible]

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Mt Olivet Cemetery July 24 1923

20-UNDERTAKER. ADDRESS

Wm Cook 507 E North Ave

Cor.—1-12-23—M&T—100 Bks.

D77727

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77727

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Fish House Road. Westport. ST., (WARD) W

2-FULL NAME George Smith.

(a) **RESIDENCE NO** Fish House Road. Westport. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) September 21, 1853.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	10	---.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince George Co. Md.

PARENTS

10 NAME OF FATHER John Smith.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Abbey Weaver.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Albert Smith. (brother) (Address) Annapolis Road. Westport.

15 JUL 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos ds.

(Signed) Otto M. Reinhardt M. D. (Coroner.)

July 21, 1923 (Address) 1047 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bal. Mem. DATE OF BURIAL: July 24 1923

20 UNDERTAKER: Pew book ADDRESS: 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77728

CERTIFICATE OF DEATH.

113 D77728

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 123 Scott ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl Wesley Feathers

(a) RESIDENCE NO. 123 Scott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Wm E. Feathers

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian M Scott

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Wm E. Feathers (Address) 123 Scott St

15 JUL 23 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1923

17

I HEREBY CERTIFY, That I attended deceased from 7/21/ 19 23 to 7/22/23 19

that I last saw h— alive on 7/22/23 19

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) History yrs. 5 days mos ds.

CONTRIBUTORY (Secondary) Gastro enteritis

(duration) 2 wks yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Bernard Levy M. D.

July 24 19 23 (Address) 1516 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	July 24 1923
20 UNDERTAKER	ADDRESS
Wm J Buckner & Sons	North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77729 ✓ D77729

CERTIFICATE OF DEATH.

188-003

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Pronounced Dead at St. Joseph Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Gomer

(Residence in Baltimore: No. 1521 E. Biddle St. St. (yrs. mos. ds.)

§ (Fix)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced (Write the word.)
female	white	sing

6-DATE OF BIRTH. May 28/1915 (Month) (Day) (Year)

7-AGE. 8 yrs. 1 mos. 7 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Pittsburg Pa.

PARENTS.

10-NAME OF FATHER: Marcel Gomer

11-BIRTHPLACE OF FATHER, (State or Country): France

12-MAIDEN NAME OF MOTHER: Bertha Margret

13-BIRTHPLACE OF MOTHER, (State or Country): France

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marcel Gomer

(Address) 1521 E. Biddle St.

15- JUL 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 21/23 (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Insp. (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull- (Front & vault)
Struck by automobile- Inquest
to be held July 23/23 8.30 P.M.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J E Howes M. D.
(Coroner)

7/22/23 (Address) 508 E North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St Marys Hampden — DATE OF BURIAL: July 23 1923

20-UNDERTAKER: W. C. Cook — ADDRESS: 502 E North

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D77730

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D77730

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., WARD)

2-FULL NAME Annie Simpson

(a) RESIDENCE NO. Bay View Asylum ST., 26 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Bureau
(Address)

15 JUL 23 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1923, to July 21, 1923, that I last saw h[illegible] alive on July 21, 1923, and that death occurred, on the date stated above, at 10:20 a.m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pernicious - Pneumonia (Terminal) (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. H. Dolsmith, M. D.

7-22 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	July 23 1923

20 UNDERTAKER mrs R. a. Elliott ADDRESS 1725 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARYLAND RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77731

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D77731

REGISTERED NO.

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1829 Aiken ST., WARD)

2-FULL NAME Maud Smith

(a) RESIDENCE NO. 1638 S. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. 3 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew J. Smith

6 DATE OF BIRTH (month, day, and year): Mar 29 - 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: Joseph Sidby

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Elizabeth Bowen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Mr Andrew J Smith

(Address) 1638 S Charles St

JUL 23 1923

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22nd 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan. 8th, 1923, to July 22nd, 1923,

that I last saw her alive on July 21, 1923,

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Dropsy

Uraemic Poisoning + Convulsions

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bright's Dis. Chron

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms, examination

(Signed) Edward C Schaaf, M. D.

, 19 (Address) 3706 Liberty Heights

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	July 25 1923
20 UNDERTAKER: Robert F. Cowan & Son	ADDRESS: 701 Hollins St
Per R F Cowan	

Spec.—1-10-21—M&T—1500 Bks.

D77732

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77732

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH South Balto General Hosp.

REGISTERED NO.

CITY OF BALTIMORE: (NO. 1213 Light ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Smith Mopson

(a) RESIDENCE NO. South Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hours or minutes
			1	Hours

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Walter T Mopson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ellovers.

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ellovers

14 Informant W. Dewey
(Address) 3102 Greenmount Ave

15 Filed JUL 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1923

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1923, to July 22, 1923, that I last saw him alive on July 22, 1923, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Premature birth,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature birth of Twin

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Nor Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. C. Warwick, M. D.

19 (Address) South Balto Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 26 1923
20 UNDERTAKER	ADDRESS
George Schilling & Son	1126 E Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

WARNING—RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

Roddiff

D77733

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77733

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1320 N. Carey ST., ... WARD)

2-FULL NAME Bennett R. Roddiff

(a) RESIDENCE NO. 1320 N. Carey ST., 16 WARD .....

(Usual place of abode) about

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Elizabeth Roddiff

6 DATE OF BIRTH (month, day, and year) June 14-1871

7 AGE 52 Years 1 Months 7 Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Day Labor

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Yorktown. Va.

PARENTS

10 NAME OF FATHER Edward Roddiff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant Elizabeth Roddiff

(Address) 1320 N. Carey St.

15 JUL 23 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 - 1923

17 I HEREBY CERTIFY, That I attended deceased from June 27 - 1923, to July 20 - 1923, that I last saw him alive on July 20 1923, and that death occurred, on the date stated above, at 5-15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) - yrs. - mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Gastritis

(duration) - yrs. - mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Symptoms

(Signed) Chas. C. McCarthy, M. D.

, 19 (Address) 2410 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forest Grove A. A. Bd. — DATE OF BURIAL: July 23, 23

20 UNDERTAKER: Sam'l W. Chase Est. — ADDRESS: 1480 Mosher

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77734

CERTIFICATE OF DEATH.

90 D77734

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 115 Scott ST., WARD)

2-FULL NAME Eliza P. Knighton

(a) RESIDENCE NO. 115 Scott ST., 18 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wht.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 5-1853

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
69	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): A. A. Co. Md.

PARENTS

10 NAME OF FATHER: Thomas Knighton

11 BIRTHPLACE OF FATHER (city or town) (State or country): A. A. Co. Md.

12 MAIDEN NAME OF MOTHER: Ellen Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): A. A. Co. Md.

14 Informant: Fannie Agnes Parker

(Address) 115 Scott St.

15 Filed JUL 23 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to July 21, 1923, that I last saw h... alive on July 21, 1923, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cardiac Hypertrophy

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wallace Thomas M. D.

July 22 1923 (Address) 1328 Cumberland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 23/23
UNDERTAKER	ADDRESS
George L. Schwaderer & Bro.	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

D77735 Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77735

CERTIFICATE OF DEATH.

179

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (NO.) 3809 Fosterbluff ST.; 16 WARD)

2-FULL NAME John James Getz

(a) RESIDENCE. NO. 3809 Fosterbluff ST.; 16 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 20 1920

7 AGE: Years 3 Months Days If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore (Highlandtown) Md

PARENTS

10 NAME OF FATHER: Joseph P. Getz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Carrie Wachter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Joseph P. Getz 3809 Fosterbluff

15 Filed JUL 23 1923, 19 — ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20, 1923

I HEREBY CERTIFY, That I attended deceased from July 17, 1923, to July 20, 1923

that I last saw h[illegible] alive on July 19 1923

and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows: Burns of Back, Rt Arm, Leg, Foot, & External Genitals Accidental falling into a hot bath water

(duration) yrs. — mos. — ds.

On July 17th at 7.40 P.M.

CONTRIBUTORY (Secondary) —— (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. L. Reichard M. D.

(Address) 1000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. — DATE OF BURIAL: July 23 1923

20 UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 E. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—190 (See Letter attached (Name) Wible) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77736

1096419

31 D77736

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S.Veterans' Hospital #56 Fort McHenry, Md.

CITY OF BALTIMORE: (No. ~~130 W. Cross St.~~ ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wible, ~~George~~ Charles M.

(a) RESIDENCE No. 170 W. Cross St. ST., WARD 8

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland, Baltimore

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Thomas D. Stinchcomb (Address) 1035 S. Hanover St

15 Filed JUL 23 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 3rd, 1922, to July 21, 1923,

that I last saw him alive on July 21, 1922,

and that death occurred, on the date stated above, at 5.15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis, chronic far advanced, active

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary, Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Positive sputum

(Signed) H. W. Barker, Surgeon, U. S. M. D.

7/24 1923 (Address) Fort McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ridge Md Milleville | DATE OF BURIAL 7/23, 1923

20 UNDERTAKER A. Feinson & Bro | ADDRESS 1127 E. Balto st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REMOVED FOR BINDING

DISTRICT No._____

UNITED STATES VETERANS BUREAU

U. S. VETERANS' HOSPITAL #56
Fort McHenry, Md.
Sept. 29, 1923.

IN REPLY REFER TO:

WIBLE, Charles M.
C-1,095,419

Registrar of Vital Statistics,
Baltimore, Md.

Sir:

Enclosed herewith is corrected Death Certificate in the case of the above named claimant who died in this hospital July 21, 1923.

Thru an error the Death Certificate was made out in the name of George Wible instead of Charles M. Wible which is the correct name according to all our records.

Respectfully,

Henry A. Smith

HENRY A. SMITH,
Surgeon, Reserve,
Medical Officer in Temp. Charge.

K.

-enc-

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks. CORRECTED COPY. made 9-27-23

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U. S. VETERANS' HOSP. #56 Ft. McHenry, Md. REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore, Md. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles M. W I B L E.

(a) RESIDENCE NO. 170 W. Cross St., ST., WARD -
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred - yrs. - mos. - ds. How long in U. S., if of foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of - - - -

6 DATE OF BIRTH (month, day, and year) - - -

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
30 years	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) - -

(c) Name of employer - -

9 BIRTHPLACE (city or town) Maryland. (State or country)

PARENTS

10 NAME OF FATHER - -

11 BIRTHPLACE OF FATHER (city or town) - - (State or country)

12 MAIDEN NAME OF MOTHER - -

13 BIRTHPLACE OF MOTHER (city or town) - - (State or country)

14 Informant Taken from Clinical Record. (Address)

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21st 19 23

17 I HEREBY CERTIFY, That I attended deceased from 11- 3-22 , 19 , to 7-21-23 , 19 , that I last saw him alive on July 21st , 19 23, and that death occurred, on the date stated above, at 5:15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis, far advanced, active.

(duration) 2 yrs. - mos - ds.

CONTRIBUTORY (Secondary) -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of - - -

Was there an autopsy? no

What test confirmed diagnosis? positive sputum.

(Signed) H. M. Barker, Surg. U. S. M. D.
Medical Officer in Temp. Charge.
, 19 (Address) Ft. McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D77737 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77737

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1633 N. Mount St. ST.: WARD)

2-FULL NAME Daniel Jones

(a) RESIDENCE. No. 1633 N. Mount ST., 10 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Daniel Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER S. J. Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Daniel Jones
(Address) 1633 N. Mount St.

15 Filed JUL 23 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 19th 1923 to July 19th 1923 that I last saw her alive on July 19th 1923 and that death occurred, on the date stated above, at 3.00 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonic Phthisis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Geo. N. Lauenbach M. D.

July 20th 1923 (Address) 3215 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M.H. Zion	July 23 1923

20 UNDERTAKER Lauer & Dennis ADDRESS 303 Gilmore

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77738 D77738

CERTIFICATE OF DEATH.

162

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1621 N. Port St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Kilbert Kireg

(a) Residence No. 1621 N. Port St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 7/22/23

7-AGE. yrs. mos. 1 hour. If LESS than 1 day, 1 hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) Balto (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Charles Kireg

11-BIRTHPLACE OF FATHER (city or town) Balto (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Margaret Hamrasek

13-BIRTHPLACE OF MOTHER (city or town) Balto (State or Country), Md.

14- (Informant) Father (Chas Kireg

(Address) 1621 N. Port St

15- JUL 23 1923 ROBERT R. KRAUER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/22/23

17- I HEREBY CERTIFY, That I attended deceased from 7/22/ 1923 to 7/22 1923

that I last saw h. alive on 7/22 1923

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Partial Asphyxia 1 hour

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Breech presentation

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical Symptoms

(Signed) Amelia E. Smith M. D

, 19 (Address) 1107 N. Caroline St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery DATE OF BURIAL, 7/23, 1923.

20-UNDERTAKER, Wm. Chas Rehde ADDRESS 600 Arlington Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77739

CERTIFICATE OF DEATH.

159-003 D77739
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital (St.:) (Ward) 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Myers

(a) RESIDENCE. No. 1701 E. Fairmount Ave. St. Ward.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Samuel Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Rebecca

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Hosp. Records
(Address)

15 Filed JUL 23 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1923

17 I HEREBY CERTIFY, That I attended deceased from July 17 1923, to July 22, 1923, that I last saw h[illegible] alive on July 22, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Esophageal atresia

(duration) since birth yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) M Bayhi M. D.

7/23/1923 (Address) 210 S. Spring St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Friendship	July 23 1923

20 UNDERTAKER ADDRESS

East Lews 1429 E. Oaks

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec—12-23-21—E.B.R.S.—400 Blks.

D77740

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77740

CERTIFICATE OF DEATH.

100-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., ... Ward) No

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Jones

(a) Residence No. Unknown St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) ?

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1865 ?

7-AGE. 58 ? yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or .... min. ?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) No

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) ? (State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) ? (State or Country).

11- (Informant) Municipal Hospital Records

(Address) .....

15- Filed ..... 19.. Registrar.

Robert P. Harrison,
Burial Permit Clerk

JUL 25 1923

9,566

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 20, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 14 19 23 to July 20 19 23

that I last saw h... alive on July 20 19 23

and that death occurred, on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Immed.) (Duration) ... yrs. ... mos. 6 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. J. Fulton M. D

7/21/1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND. DATE OF BURIAL. ..... 19....

20-UNDERTAKER Commissioner of Health. ADDRESS JUL 23 1923

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D77741 HEALTH DEPARTMENT—CITY OF BALTIMORE D77741

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH Registered No.

City of BALTIMORE: (No. Municipal Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Deal.

(a) Residence No. 807 Peach Alley St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Black

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1883 ?

7-AGE. 40 ? yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Md

PARENTS.
10-NAME OF FATHER: — Deal
11-BIRTHPLACE OF FATHER (city or town) (State or Country): Unknown
12-MAIDEN NAME OF MOTHER: Unknown
13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Unknown

14- (Informant) Municipal Hospital Records
(Address)

15- Filed JUL 23 1923 Robert P. Harrison, 192 Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 20, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 19 19 23 to July 20 19 23
that I last saw him alive on July 20 19 23
and that death occurred, on the date stated above, at 4:30 P.M.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes Autopsy

What test confirmed diagnosis?

(Signed) A. Goldsmith M. D.

7-21 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL. July 24 1923

20-UNDERTAKER: R. F. Parham

ADDRESS 602 Ladew Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77742

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 47 D77742

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2033 N. Washington St. WARD)

2-FULL NAME Mary E. Eckhardt.

(a) RESIDENCE No. 2033 N. Washington St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mns. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 7, 1872

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
50	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Pensterton Md.

PARENTS

10 NAME OF FATHER: Conrad Eckhardt.

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Gunther

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. E. Eckhardt

(Address): Pensterton Md.

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 6, 1922, to July 22, 1923,

that I last saw her alive on July 22, 1923

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

(a) Carcinoma of Breast

Vertebra & Liver

(duration) 1½ yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) 1½ yrs. mos. ds.

18 Where was disease contracted if not at place of death? New York

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & X Ray

(Signed) [illegible], M. D.

7-23, 19 (Address) 1707 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	July 24 1923
20 UNDERTAKER	ADDRESS
A. Kleman & Son	324 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of PLACE OF DEATH is very important. See Instructions on back of certificates.

Robert E. Merriken,
Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

D77743

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1/3

D77743

1-PLACE OF DEATH University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hosp ST., WARD)

2-FULL NAME Joseph Eastman

(a) RESIDENCE NO. St Vincents Orphanage ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant St Vincents Orphanage

(Address) 1511 Druid Hill Ave

15 Filed JUL 23 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22 1923

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1923. to July 22, 1923.

that I last saw him alive on July 22, 1923

and that death occurred, on the date stated above, at 1:15 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (ileo colitis)

(duration) yrs. mos. 2½ ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? What test confirmed diagnosis? Clinical findings

(Signed) J. Taylor M.D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL July 24 1923

20 UNDERTAKER Martin Eaky & Son

ADDRESS 1827 W North Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77744

CERTIFICATE OF DEATH.

90

D77744

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) 1816 (ST.) Warwick Av (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Cronin

(a) RESIDENCE. NO. 1816 (ST.) Warwick Av (WARD) 11

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Patrick Cronin

6 DATE OF BIRTH (month, day, and year): Sept. 30-1856

7 AGE — Years: 66 — Months: 9 — Days: 22 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thos. Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Grady

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Iceland

14 Informant (Address): Mrs. Owens 1816 Warwick

15 Filed JUL 23 1923

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1923, to July 22, 1923, that I last saw her alive on July 19, 1923, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis (duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Chronic Rheumatism (duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. B. Lynch, M. D.

(Address) Walbrook & Division

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Govans	July 25 1923

20 UNDERTAKER: Martin Tracy Sons — ADDRESS: 1837 W. North

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77745 D77745

CERTIFICATE OF DEATH. 31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1347 Sargent St., Ward)

2-FULL NAME Frank T. Hess

(a) RESIDENCE No. 1347 N. Sargent St., W 1 Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dora Hess

6 DATE OF BIRTH (month, day, and year): Feb 26 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Builder

(b) General nature of industry, business, or establishment in which employed (or employer): Building

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: L Hess

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Dora Hess

(Address): 1347 Sargent St

15 Filed JUL 23 1923 19 ..... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1923

17 I HEREBY CERTIFY, That I attended deceased from October, 1922, to July 23, 1923; that I last saw him alive on July 22, 1923, and that death occurred, on the date stated above, at 10-35 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Bacteriological

(Signed) Edgar E. Figaro, M. D.

19 (Address) 1515 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: July 26 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Hoffman

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77746

CERTIFICATE OF DEATH.

31

D77746

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 S. Fremont St. WARD)

2-FULL NAME Frank M. Ziegler

(a) RESIDENCE No. 606 S. Fremont St. WARD 17

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 23 1864

7 AGE Years 59 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Handyman

(b) General nature of industry, business, or establishment in which employed (or employer) 2

(c) Name of employer Amecan Shaved Co

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER H. A. Ziegler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Caroline Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mary D. Claudige

(Address) 606 S. Fremont

15 Filed JUL 23 1923, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1923

17

I HEREBY CERTIFY, That I attended deceased from June 18 1923, to July 21st 1923.

That I last saw h[illegible] alive on July 19th 1923.

And that death occurred, on the date stated above, at 7:40 m.

The CAUSE OF DEATH* was as follows:

Heart Failure

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis Endocarditis

(duration) yrs. 11 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Poulton, M. D.

7/24/23 (Address) 3909 Gunsmane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore DATE OF BURIAL July 24 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E Nall

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77747 ✓ 57 D77747

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1815 E Chase ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lydia V. Lancaster

(a) RESIDENCE NO. 1815 E Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 11 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W. Lancaster

6 DATE OF BIRTH (month, day, and year): Aug 5 1846

7 AGE — Years: 76 Months: 11 Days: 17 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: James Van Horn

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Malvina Pastorfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Maryland

14 Informant: Mrs Hesse (Address) 1815 E Chase st

15 Registrar: Edgar P. Harrison; Burial Permit Clerk

JUL 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 1923

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1923, to July 22 1923, that I last saw her alive on July 22, 1923 and that death occurred, on the date stated above, at 4. P. m.

The CAUSE OF DEATH* was as follows:

exhaustion & starvation — refused food

(Last.) gangrene of leg

(Thrombus)

(duration) yrs. 2 mos — ds.

CONTRIBUTORY (Secondary): diabetes mellitus

(duration) 1 yr. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) H. Warnger, M. D.

19 (Address) 1145 S. Wood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Louden Park — DATE OF BURIAL: July 26 1923

20 UNDERTAKER: J. Henry Lutz — ADDRESS: 1203 N. Broadway

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77748

CERTIFICATE OF DEATH.

1163 D77748

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 743 N. Sarah Ann ST. 4 WARD)

2-FULL NAME Helen Banks

(a) RESIDENCE NO. 743 N Sarah Ann ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 7, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Charles Dammond

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Georgiana Banks

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Georgiana Banks (mother)
(Address) 743 N. Sarah Ann

15 Filed ..., 19.. ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1923, to July 21, 1923, that I last saw her alive on July 21, 1923, and that death occurred, on the date stated above, at 6:15 P. m.

THE CAUSE OF DEATH* was as follows:

(a) Gastro enteritis

(duration) yrs. mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? observation

(Signed) Dr. E. Wells, M. D.

, 19 (Address) 154 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL 7-24 19 3

20 UNDERTAKER: Daniel Eccleston — ADDRESS 916 Gay av

JUL 23 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Theodore Smith)

D77749

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77749

CERTIFICATE OF DEATH.

182

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. St. Ag Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theo Smith

(Residence in Baltimore: No. 2707 Fredrick Ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: January 3rd 1

(Month) (Day) (Year)

7-AGE: 1 yrs. 6 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto.

PARENTS:

10-NAME OF FATHER: Charles Smyth

11-BIRTHPLACE OF FATHER, (State or Country): Balto.

12-MAIDEN NAME OF MOTHER: Barbara L. Goff

13-BIRTHPLACE OF MOTHER, (State or Country): Balto.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles Smith

(Address) 2709 Frederick Ave.

15- Filed ..... 192.....

Robert F. Harrison,

Burial Permit Clerk, Registrar.

JUL 23 1923

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July 22 192 3

(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Traumatic Peritonitis

ocw

(Duration) ... yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Jumping Accident

(Duration) ... yrs. ... mos. ... ds.

(Signed) Geo Calhoun Blades M. D.

July 23 1923 (Coroner)

(Address) 1402 N. Gray

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park DATE OF BURIAL: July 24 1923

20-UNDERTAKER: George L. Schwab ADDRESS: 1210 Fredk Ave.

Spec.—1-10-21—M&T—1500 Bks.

165116 D77750

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 118-002

D77750

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

2-FULL NAME John Green.

(a) RESIDENCE NO. Lonaconing, Md, P.O. Box 422. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Green Wife

6 DATE OF BIRTH (month, day, and year): Dec 10, 1889

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
33	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): 986

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John W. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Annie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant (Address): Records

15 JUL 24 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1923

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1923, to July 23, 1923,

that I last saw him alive on July 23, 1923,

and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction
Post operative

(duration) yrs. mos 4 da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 15, 1923

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) F. L. Reichert, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lonaconing 3d

DATE OF BURIAL: July 26 1923

UNDERTAKER: Wm. J. Jones & Son

ADDRESS: Fort Hill Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77751

CERTIFICATE OF DEATH.

31 D77751

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 E. York St. ST., WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Patrick Burns.

(a) RESIDENCE NO. 111 E. York St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? 26 yrs. --- mos. --- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Charles W. Kessler. (Address) 111 E. York St.

15 Filed JUL 24 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage.

Pulmonary Tuberculosis. (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) ... yrs. ... mos. ... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

July 23, 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL July 24 1923

20 UNDERTAKER Margaret L. Flynn — ADDRESS 1422 Light St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77752

CERTIFICATE OF DEATH.

129 D77752

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1342 Woodyear ST., ... WARD)

2-FULL NAME Robert Frederick

(a) RESIDENCE No. 1342 Woodyear ST., 16 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Common Labor

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jno. H. Frederick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Grace Frederick

(Address) 1342 Woodyear St

15 JUL 24 1923 ROBERT N. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1923 to July 21, 1923.

that I last saw him alive on July 21, 1923.

and that death occurred, on the date stated above, at 8:40 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) yrs ..... mos 4 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis about 6 mos. + ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Youngmans M. D.

(Address) 1019 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn.	July 24 23

20 UNDERTAKER James H. Lewis ADDRESS 1303 Druid Ave

Spec.—1-10-21—M&T—1560 Bks.

D77753

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D77753

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2600 Mc Elderry ST., WARD)

2-FULL NAME Margaret Rittenbaugh

(a) RESIDENCE NO. 2600 Mc Elderry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry F. Rittenbaugh

6 DATE OF BIRTH (month, day, and year): June 30, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Co

PARENTS

10 NAME OF FATHER: John Lechthaler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Klahr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Henry F. Rittenbaugh 2600 Mc Elderry

15 Filed JUL 24 1923 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1923, to July 21, 1923.

That I last saw her alive on July 21, 1923.

and that death occurred, on the date stated above, at 3.40 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorrhage

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Margaret Rowlands, M. D.

7/23, 1923 (Address) 2124 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oaklawn — DATE OF BURIAL: 7/24 1923

20 UNDERTAKER: Fuhrer & Fuhrer — ADDRESS: 1734 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77754

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

75-002 D77754

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28th WARD)

2-FULL NAME Mrs Agnes Condon

(a) RESIDENCE. No. Mt Hope Retreat ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 7 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow -

5a If married, widowed, ~~or divorced~~ ~~HUSBAND of~~ (or) WIFE of Mr Condon -

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	72	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md -

PARENTS

10 NAME OF FATHER C. Ryan

11 BIRTHPLACE OF FATHER (city or town) (?) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elinor Bolan

13 BIRTHPLACE OF MOTHER (city or town) (?) (State or country) Ireland -

14 Informant Records of Mt Hope (Address) Retreat

15 Filed JUL 24 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1923

17 I HEREBY CERTIFY, That I attended deceased from May 13th, 19..., to July 23, 19..., that I last saw her alive on July 21, 19..., and that death occurred, on the date stated above, at 6:45 a. m.

The CAUSE OF DEATH* was as follows:

Paralysis - Post Senile Atheroma

abt 6 or 7 wks.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis -

abt 6 or 7 wks
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery M. D.

19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: July 25 1923

20 UNDERTAKER: Johannah & Charles — ADDRESS: 1004 Virginia Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77755

CERTIFICATE OF DEATH.

31 D77755

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 N. Central Ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Cooper

(Residence in Baltimore: No. 522 N. Central Ave St.; 44 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
F	C	Single

6-DATE OF BIRTH, May (Month) 5 (Day), 1893 (Year)

7-AGE, 30 yrs. mos. da. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER. William Cooper

11-BIRTHPLACE OF FATHER (State or Country). Balto Md

12-MAIDEN NAME OF MOTHER Jane Nixon

13-BIRTHPLACE OF MOTHER (State or Country). Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mylde Cooper

(Address) 522 N. Central ave

15- Filed JUL 24 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 22 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1923, to July 22 1923, that I saw her alive on July 21 1923, and that death occurred, on the date stated above, at 12 30 A.m.

The CAUSE OF DEATH* was as follows:

Pulm T.B. (1)

(Duration) 3 yrs. mos. da.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) 3 yrs. mos. da.

(Signed) R. Young M. D.

7/23, 1923 (Address) 1924 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. da. In the State yrs. mos. da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Laurel Cemetery DATE OF BURIAL. July 24 1923

20-UNDERTAKER Mrs. Chas. B. Jones ADDRESS 122 Eastlander

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77756

CERTIFICATE OF DEATH.

197 D77756

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., WARD)

2-FULL NAME Anna Smith

(a) RESIDENCE NO. 915 Harris alley ST., 11 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colo	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
42 yrs			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mary Reed
(Address) 10 E. McCulloh

15 JUL 24 1923 ROBERT R. KRAUTER, Registrar Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Interval Hemorrage Shock

(duration) yrs. 4 days mos. ds.

CONTRIBUTORY (Secondary) Shot by woman as this was unknown

(duration) yrs. mos. da.

(Signed) W. B. Gonzales, M. D. (Coroner.)

July 24, 1923 (Address) 1117 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	July 24 1923
20 UNDERTAKER Mrs. R. A. Elliott	ADDRESS 1117 Edmondson

N. B.—WRITE LEGIBLY. MAKE ENTRIES WITH INK. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77757

CERTIFICATE OF DEATH. 100-001

D77757

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 2d (WARD)

2-FULL NAME John George Ittner

(a) RESIDENCE NO. 900 block Columbia Ave. + Fremont ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (Write the word)
Male	white	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of 9

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Carver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed JUL 24 1923 ROBERT H. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1923

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1923, to July 22 1923, that I last saw h.. alive on July 22, 1923, and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (Terminal) (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Wm. J. Fulton M. D.

7-24 1923 (Address) City Hospital, Bay View.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	July 24 1923
20 UNDERTAKER Ralph B. Cook	ADDRESS 1003 N. Bolton St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77758

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

174-001 D77758

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. En route St. Joseph Hospital St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... William Quinn

(Residence in Baltimore: No. 230 N. Greene St. St(yrs. 30 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	White	Single

6-DATE OF BIRTH, ... unknown ..... 1.....
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
....55....yrs.....mos.....ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Farm Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country), "

12-MAIDEN NAME OF MOTHER, "

13-BIRTHPLACE OF MOTHER, (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles V. Tanner

(Address) 230 N. Greene St.

15- JUL 24 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... July 21/23 ....., 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... Inquiry .....
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said ..... Inquiry ..... find that said deceased came to ..... death
(Inquest, autopsy or inquiry.)
on the day stated above.
The CAUSE OF DEATH* was as follows:

Probably Apoplexy

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) .....yrs.....mos.....ds.

(Signed) ..... M. D.
(Coroner)

7/24/23 192... (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Fredon Park Penn	July 27 1923
20-UNDERTAKER,	ADDRESS
H. M Routson	230 N Greene

Spec.—1-10-21—M&T—1500 Bks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77759

CERTIFICATE OF DEATH.

152

D77759

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 154 N Hilton ST., WARD)

2-FULL NAME John S Dow

(a) RESIDENCE NO. 154 N Hilton ST. 20 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 3 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A Dow nee McLaw

6 DATE OF BIRTH (month, day, and year) March 28 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Lower decks

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Adam McLaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Margaret O'Neill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs J Herzog (Address) 1511 N Hilton St

15 JUL 24 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23rd 1923

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1923, to July 23, 1923

that I last saw him alive on July 23, 1923

and that death occurred, on the date stated above, at 1:30 a m.

The CAUSE OF DEATH* was as follows:

Carbuncle

(duration) , yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Henry Glassman, M. D.

1923 (Address) 2687 Wes Lees Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	July 25 1923

20 UNDERTAKER Colin J Cowan & Son — ADDRESS 608 Holliday St

Per J J Cowan

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77760

CERTIFICATE OF DEATH.

105 D77760

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 N. Washington ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Nelson

(a) RESIDENCE NO. 1319 N. Washington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. — mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Martin H. Nelson

6 DATE OF BIRTH (month, day, and year) July 4th 92

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	—	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Adam Urban

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Grace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Martin H. Nelson

(Address) 1319 N Washington

15 JUL 24 1923 ROBERT J. KRAUTER, Registrar. Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1923

17 I HEREBY CERTIFY, That I attended deceased from May 2 . 19 . to July 23 . 1923

that I last saw her alive on July 23 . 1923

and that death occurred, on the date stated above, at 3 45 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Exam

(Signed) O. V. Kelly M. D.

July 23 1923 (Address) 100 N Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 7/26 1923

20 UNDERTAKER Philip Hennig — ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77761

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

164

D77761

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 740 Light ST., WARD)

2-FULL NAME Ida O.Bode

(a) RESIDENCE NO. 740 Light ST., 22 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 5 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Selmer W.Bode

6 DATE OF BIRTH (month, day, and year) Feb.10 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	73	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER James Wonn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Mary A.Gold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Gold Bode

(Address) 740 Light Street

15 Filed JUL 24 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1923

17 I HEREBY CERTIFY, That I attended deceased from July 17 1923 to July 22 1923,

that I last saw her alive on July 22 1923,

and that death occurred, on the date stated above, at 10 P.M. m.

The CAUSE OF DEATH* was as follows:

Infirmities of age.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. Edward Smith M. D.

7/23 1923 (Address) 910 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL July 25 1923

20 UNDERTAKER John H. Denny

ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77762

CERTIFICATE OF DEATH.

90 D77762
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 632 N. Hilton ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Allen Little

(a) RESIDENCE NO. 632 N. Hilton ST., 16 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Little

6 DATE OF BIRTH (month, day, and year) Jan 11. 1764

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Seward & Matthews

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas Allen Little

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Sarah McAdams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co, Md

14 Informant Mrs Annie E. Little
(Address) 632 N. Hilton st

15 JUL 24 1923 ROBERT R. KRAUTER Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1923

17 I HEREBY CERTIFY, That I attended deceased from June 16 1923 to July 21 1923.

that I last saw him alive on July 20 1923.

and that death occurred, on the date stated above, at 2 30 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis,

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical ex

(Signed) J. M. Lamborn M. D.

(Address) 826 N Carrollton av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	July 24 1923

20 UNDERTAKER For Jourdan & Son ADDRESS 217. E. Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77763

CERTIFICATE OF DEATH.

11-002 D77763

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1712 W Fayette St ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Downs Schuster.

(a) RESIDENCE. NO. 1712 W Fayette ST., 11 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Schuster

6 DATE OF BIRTH (month, day, and year) May 19. 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York Co Penna

PARENTS

10 NAME OF FATHER Wm Campbell.

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Co Penna

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant John J. Schuster
(Address) 1712 W Fayette St

15 JUL 24 1923 ROBERT R. KRAUTER, Assistant Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Apr 6, 1923, to July 21, 1923, that I last saw her alive on July 21, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. 3 mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M J Hanna, M. D.

, 19 (Address) 1822 W Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 25 1923
20 UNDERTAKER	ADDRESS
George J Smith	1532 Hollins st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77764

CERTIFICATE OF DEATH.

161-001 D77764

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 801 Greenmount Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME not named (Infant McAllister)

(a) Residence No. 801 Greenmount Ave St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Not

6-DATE OF BIRTH (month, day and year) July 22/23

7-AGE. ....yrs. ....mos. ....ds. If LESS than 1 day, 1/2 hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, George McAllister

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Philadelphia Pa

12-MAIDEN NAME OF MOTHER, Anne Mitchell

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant) Anne Mitchell

(Address) 801 Greenmount Ave

15- Filed JUL 24 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 22/23

17- I HEREBY CERTIFY, That I attended deceased from July 22 1923 to July 22 1923

that I last saw h[illegible] alive on July 22 1923

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth at 5½ mths uterogestation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) I W Keown M. D.

July 23, 1923 (Address) 1938 Linden Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, HOPKINS HOSPITAL — DATE OF BURIAL, ... 19....

20-UNDERTAKER. — ADDRESS

Commissioner of Health, JUL 23 1923

N. B.—WRITE PLAINLY, WITH INKS OR PENCILS. All questions should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

228

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77765 CERTIFICATE OF DEATH. 161-001 D77765

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 517 W. Cross ST., WARD)

2-FULL NAME Infant Langford

(a) RESIDENCE NO. 517 W Cross ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 7/21/23

7 AGE: Years —; Months —; Days 1; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Edw. W Langford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Myrtle Boggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant ... (Address) ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/22/1923

17 I HEREBY CERTIFY, That I attended deceased from 7/21/1923 to 7/22/1923 that I last saw him alive on 7/21/1923 and that death occurred, on the date stated above, at 6:30 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

Labor

(duration) ... yrs. 6 mos. duration ds.

CONTRIBUTORY (Secondary) Fall - accidental

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Clinton Cowley, M. D.

(Address) 908 S Ann St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL ... 19 ...

20 UNDERTAKER

ADDRESS

JUL 24 1923 ROBERT R. KRAMER, Commissioner Health, Registrar

JUL 23 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

2238

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77766

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77766

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1922 Etting ST.; WARD)

2-FULL NAME Viola Geiser

(a) RESIDENCE. NO. 1922 Etting ST., 14 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joe Geiser

6 DATE OF BIRTH (month, day, and year) July 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Aaron Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER May Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Aaron Hunt

(Address) 1924 Etting St

15 JUL 24 1923 ROBERT R. KRAMER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1923

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1923, to July 22, 1923, that I last saw h alive on July 22, 1923, and that death occurred, on the date stated above, at 2.50 P m. The CAUSE OF DEATH* was as follows:

Tuberculosis of the Lungs

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion from heart

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) W. H. Martin, M. D.

, 19 (Address) 2008 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	7/25/23
20 UNDERTAKER Gest Tarpison	ADDRESS 573 Lemmon

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77767

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 D77767

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 947 W Lexington St (St.) (Ward) 18

2-FULL NAME Julia Custy

(a) RESIDENCE. (No.) 947 W Lexington St (St.) (Ward.)
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced · HUSBAND of (or) WIFE of: Patrick Custy

6 DATE OF BIRTH (month, day, and year): Oct. 1. 1843

7 AGE: Years 79. Months 9. Days. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: Irish.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Cuskerin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs Mary Murphy 947 W Lexington St

15 Filed JUL 24 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to July 22, 1923,

that I last saw her alive on July 21, 1923,

and that death occurred, on the date stated above, at 11.30 p m.

The CAUSE OF DEATH* was as follows:

Cancroma Duodenum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Old age.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M G Finnegan M.D.

7/23/23 (Address) 682 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: 7-25 1923

20 UNDERTAKER: H. Browning & Son

ADDRESS: 5th & Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77768

CERTIFICATE OF DEATH.

46 D77768

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1821 E Biddle ST., ... WARD)

2-FULL NAME Annie Kline

(a) RESIDENCE No. 1821 E Biddle ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis P Kline

6 DATE OF BIRTH (month, day, and year): Sept 12-1868

7 AGE — Years: 54 Months: 10 Days: 13 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

(c) Name of employer: .....

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Conrad Schaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dora Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Louis P. Kline

(Address): 1821 E Biddle St

15 JUL 24 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1923, to July 23, 1923,

that I last saw h alive on July 23 1923,

and that death occurred, on the date stated above, at 3:55 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Frederick J. Haines M. D.

July 25, 1923 (Address) 1301 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: July 25 1923

20 UNDERTAKER: John Ulrich

ADDRESS: 2008 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Each item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D77769

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Emmanuel Chambers

(a) RESIDENCE NO. 209 Oak St ST., Lynchburg Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Unknown 1902

7 AGE	Years	Months	Days	If LESS than 1 day, .. hrs. or ..... min.
	21	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal miner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Ancel

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Virginia

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL
(Address)

15 JUL 24 1923 . 19 Robert F. Garrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 19 23

17 I HEREBY CERTIFY, That I attended deceased from July 5 , 19 23 , to July 21 , 19 23

that I last saw he alive on July 21 , 19 23

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Rheumatic fever

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas H Bagg M. D.

. 19 Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Howsville Va.

DATE OF BURIAL 7/25 1923

20 UNDERTAKER Jas Wm Shinnick

ADDRESS 1011 E. Madison

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77770

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77770

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat ST.: 2 8th (WARD)

2-FULL NAME Mary Fannon

(a) RESIDENCE. No. Mt Hope Retreat ST. 25 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 6 mos. 18 ds. How long in U. S., if of foreign birth? Never Removed ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If ~~married, widowed, or divorced~~ (or) WIFE of Mr Fannon

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	68	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (?)
(State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick J Connelly

11 BIRTHPLACE OF FATHER (city or town) (?)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER (?)

13 BIRTHPLACE OF MOTHER (city or town) (?)
(State or country) Ireland (?)

14 Informant Record of Mt Hope Retreat
(Address) Baltimore Md

15 Filed JUL 24 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23rd 1923

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1923, to July 23rd, 1923, that I last saw her alive on July 22nd, 1923, and that death occurred, on the date stated above, at 9.45 A.M.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis with Senile & Cerebral Atherosis —

Abt (duration) 4 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Senile Psychosis

Abt (duration) 4 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery M. D.

July 25th, 1923 (Address) Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	July 24 1923
20 UNDERTAKER	ADDRESS
H. C. Wadefield	914 Greenmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state at once CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77771 D77771

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4016 Hawthorne Ave ST. (WARD) 43

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Lenkuhl Aiken

(a) RESIDENCE NO. 4016 Hawthorne Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. H. Aiken, Jr.

6 DATE OF BIRTH (month, day, and year) Sept. 5, 84.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	38	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Lenkuhl.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Elbring.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. Wm. H. Aiken, Jr.

(Address) 4016 Hawthorne Ave.

15 Filed Roberts P. Hemsley Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1923

17

I HEREBY CERTIFY, That I attended deceased from July 11, 1922 to July 24, 1923.

that I last saw h.. alive on July 24, 1923.

and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Peritonitis.

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. Merritt Sorrell M. D.

, 19 (Address) 370 Liberty Hgts. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	July 26 1923
20 UNDERTAKER	ADDRESS
W. J. Dickerson Sons	North & Penna Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77772

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77772

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 306 E. Randall ST., WARD) N

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Levi Brandenburg

(a) RESIDENCE NO. 306 East Randall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Brandenburg

6 DATE OF BIRTH (month, day, and year) April 15 1859

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
64	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) United R. & E. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Agnes Brandenburg (Address) 306 E Randall

Filed JUL 24 1923, 19 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22nd 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 9th, 1923, to July 21st, 1923, that I last saw him alive on July 21st, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma over left mastoid with extensive infiltration of glands along left carotid.

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Ex Lanation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? yes Date of Jan-15/1923

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. F. Burton, M. D.

7/24, 1923 (Address) 301 East Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn, Cunall Co. Md	7/25/1923
20 UNDERTAKER E. J. Fanning	ADDRESS 1460 Druid Hill Ave

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back

Spec.—1-10-21—M&T—1500 Blks.

D77773 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D77773

CERTIFICATE OF DEATH. X 60-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Nuttall Dawson.

(a) RESIDENCE NO. Brookeville ST., WARD Florida.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Songchaland, New York.

PARENTS

10 NAME OF FATHER Marion Lindsay Dawson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Alice Taylor.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia.

14 Informant Mr. Thomas R Taylor (Address) Washington D.C.

15 Filed JUL 24 1923 Robert T. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23, 1923.

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1923, to July 23, 1923, that I last saw h[er] alive on July 23, 1923, and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goitre.

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Embolism.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Brookeville, Florida

Did an operation precede death? Yes Date of July 23, 1923

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Jno. T. Finney Jr. M. D.

July 25th 1923. (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Brookville. Fla.

DATE OF BURIAL 7-27-1923

20 UNDERTAKER Evergy Funeral Home Co

ADDRESS McCullough Orchard

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77774

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77774

CERTIFICATE OF DEATH. 159-003

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. MARYLAND GENERAL HOSPITAL ST., WARD)

2-FULL NAME INFANT OSMOND

(a) RESIDENCE No. 3212 WESTWOOD AVE ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 MINUTES yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
FEMALE	WHITE	SINGLE

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7-21-23 11½ P.M.

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or 5 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work NONE

(b) General nature of Industry, business, or establishment in which employed (or employer) NONE

(c) Name of employer NONE

9 BIRTHPLACE (city or town) (State or country) BALTIMORE

PARENTS

10 NAME OF FATHER HAROLD OSMOND

11 BIRTHPLACE OF FATHER (city or town) (State or country) MALDEN MASS.

12 MAIDEN NAME OF MOTHER BERNICE TYLER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) CHARLESTOWN. MASS.

14 Informant MRS BERNICE OSMOND (Address) 3212 WESTWOOD AVE

15 [illegible] 19 Robert L. Bernoons Registrar

JUL 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-21-23

17

I HEREBY CERTIFY, That I attended deceased from 7-21-23, to 7-21-23,

that I last saw h— alive on 7-21-23, 19 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Atelectasis Congenital Malformation Co

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? Nothing Date of 7-21-23

Was there an autopsy?

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Jno A Krupkins, M. D.

, 19 (Address) 3212 Westwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MD. GEN. HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER: None. — ADDRESS

JUL 24 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occu- TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT → CITY OF BALTIMORE ✓ D77775

CERTIFICATE OF DEATH.

D77775

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 Mc Elderry St. ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Smith

(a) RESIDENCE. NO. 1611 Mc Elderry ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	colored	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unk. 1876

7 AGE Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer - Odd

(b) General nature of industry, business, or establishment in which employed (or employer) brick yard

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Louis Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ella Armstrong

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Carrie Smith
(Address) 1611 Mc Elderry St

15 Filed Jul 24 1923 Robert F. Carrington Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1923

17 I HEREBY CERTIFY, That I attended deceased from July 8 1923, to July 22 1923, that I last saw h[illegible] alive on July 22 1923, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Aortic disruption

(duration) ____ yrs. 4 mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(duration) ____ yrs. 4 mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J Edward Johns M. D.

. 19 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Port Bello St Marys Co Md	7/25/23

20 UNDERTAKER Robert Edw Williams ADDRESS 1612 E Monument St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S should state AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77776 ✓ D77776

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1803 Patterson Park Ave. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John W. Berg

(a) Residence No. 208 Hamilton Ave. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Magdalena Berg

6-DATE OF BIRTH (month, day and year) July 23, 1864

7-AGE.	If LESS than 1 day,
59 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... Pool Room

(b) General nature of industry, business, or establishment in which employed (or employer) ..... Self

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Norway

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Norway

12-MAIDEN NAME OF MOTHER, Magdalena Berg Turner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Norway

14- (Informant) Laura Thornton

(Address) 1803 N. Patterson Park Av.

15- Robert F. Harrison, Registrar.

JUL 24 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 23 1923.

17- I HEREBY CERTIFY, That I attended deceased from July 20, 1923 to July 22, 1923

that I last saw him alive on 1923

and that death occurred, on the date stated above, at 1.25 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

.....

.....

.....

.....

.....(Duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia

.....(Duration) ..... yrs. ..... mos. 3 ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Edw. J. Cookson, M. D.

7/23/, 1923 (Address) 24 N. Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state: (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cemetery	July 25, 1923
20-UNDERTAKER.	**ADDRESS**
Wm. Cook.	502 E. North

WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77777

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77777

CERTIFICATE OF DEATH.

X 49

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Pettit

(Residence in Baltimore: No. Elizabeth W. Va. St.; yrs. ..... mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	married

6-DATE OF BIRTH, June 22/1860 (Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
63 yrs. 1 mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work unknown
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), W.Va.

PARENTS.

10-NAME OF FATHER, Nathaniel Pettit

11-BIRTHPLACE OF FATHER, (State or Country), Penna

12-MAIDEN NAME OF MOTHER, Matty Sires

13-BIRTHPLACE OF MOTHER, (State or Country), W.Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fanny Pettit

(Address) Elizabeth W.Va.

15- Robert P. Harrison, 192.....

JUL 24 1923 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 24/23 (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Nephritis- Hydronephrosis

(Autopsy at Hospital)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Carcinoma of Prostate.

(Duration).....yrs.....mos.....ds.

(Signed) J. S. A. Potter M. D. (Coroner.)

7/24/23 192.... (Address) 500 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Elizabeth W.Va.	July 24 1923
UNDERTAKER	ADDRESS
J. Sander Sons	1310 Pearl St.

(1)—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

D77778

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-021 D77778

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1029 W Lexington ST., ... WARD)

2-FULL NAME Rev Thomas H Williams

(a) RESIDENCE NO. 1029 W Lexington ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Williams

6 DATE OF BIRTH (month, day, and year) Oct 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	50	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Minister

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Mortimer Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sophia Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Chas. Young

(Address) 218 Johnson St

15 Filed ..... Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1923, to July 23, 1923, that I last saw him alive on July 23, 1923, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Dropsy & Bright Disease (duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Dropsy & Bright Disease (duration) yrs. 5 mos. 16 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D S Weymouth M. D.

7-24 1923 (Address) 701 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL July 25 1923

20 UNDERTAKER Clarence E Wolfe — ADDRESS 1364 Ramsay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sho CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77779 HEALTH DEPARTMENT—CITY OF BALTIMORE D77779

CERTIFICATE OF DEATH.

32

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 836 N Peter ST., WARD) 1

2-FULL NAME John M. Carman

(a) RESIDENCE NO. 836 N Peter ST., WARD N

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed,~~ or ~~Divorced, (write the word)~~
Male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 12-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	2	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Carman

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Lillian Newburg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va [redacted]

14 Informant Amelia Carman

(Address) 836 N Peter St

15 Filed [redacted] 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1923

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1923, to July 23, 1923.

That I last saw her alive on July 23, 1923, 4:30 P.M.

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wesley Strong M. D.

July 24 1923 (Address) 729 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Linden Park Cem	July 25 1923
20 UNDERTAKER	ADDRESS
Jos Goessens Son	2179 Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77780 D77780

CERTIFICATE OF DEATH.

1-001

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mercy Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Gelbaum

(a) Residence No. 2608 Maryland Ave St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) July 28 1918

7-AGE. 4 yrs. 11 mos. 25 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) None

(c) Name of employer .....

9-BIRTHPLACE (city or town) Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Wm. Gelbaum

11-BIRTHPLACE OF FATHER (city or town) Md
(State or Country),

12-MAIDEN NAME OF MOTHER, Virginia Morsalin

13-BIRTHPLACE OF MOTHER (city or town) Md.
(State or Country),

14- (Informant) Hospital Records.

(Address) .....

15- Robert P. Harrison,
JUL 24 1923 192 Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 24 1923

17- I HEREBY CERTIFY, That I attended deceased from 7/15/23. 19.... to 7/24/23 19.....

that I last saw h.. alive on 7/24/23 19.....

and that death occurred, on the date stated above, at 12.20 a m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever.

.....

.....

.....

(Duration) .... yrs. .... mos. 7 .... ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) .... yrs. .... mos. 48 hrs. ds.

18-Where was disease contracted if not at place of death? appendectomy

Did an operation precede death? No Date of 7/15/23

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) N. W. Goldberg M. D

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL, 7/26, 1923

UNDERTAKER, Taylor Sullivan & Hayette — ADDRESS

B—WRITE PLAINLY, WITH UNFADING INK. CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very Important

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77781 D77781

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH Boy View Hospital

CITY OF BALTIMORE, (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Rise

(a) RESIDENCE No. 722 W. Saratoga ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M ✓ | 4 COLOR OR RACE Black | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Rise

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE 35 | Years | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wayland Baltimore

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) do

14 Informant (Address) Boy View Hospital Balto, Md.

15 JUL 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1923

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1923 to July 23 1923
that I last saw h alive on July 23 1923
and that death occurred, on the date stated above, at 9:30 p. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Terminal)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) General Paralysis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Analysis

(Signed) N. Goldsmith M. D.

, 19 (Address) Boy View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem | DATE OF BURIAL 7/26 1923

20 UNDERTAKER Jno A Joadin | ADDRESS 142 W Hill St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77782

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77782

CERTIFICATE OF DEATH.

161-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Died en-route Johns Hopkins Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John M. Whittington

(Residence in Baltimore: No. 218 Cole Ave. (Raspburg) St.; yrs. mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	

6-DATE OF BIRTH. July 24/23 1.....
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
....yrs....mos....ds.	4 hours hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Jos. R. Whittington

11-BIRTHPLACE OF FATHER. (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Frances Lowwer

13-BIRTHPLACE OF MOTHER. (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos. R. Whittington

(Address) 218 Cole Ave

15- ROBERT N. KRAUTER

Filed ..... 19?? Burial Permit ..... Registrar.

JUL 25 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 24/23 19??
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity- 7 mons. gestation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. H. Cook M. D.
(Coroner)

7/25/23 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.... yrs.... mos.... ds. In the State.... yrs.... mos.... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cemetery	July 25 1923

20-UNDERTAKER.	ADDRESS
Jos. J. Merryman & Son	156 N. Eutaw

Spec—12-23-21—E.B.R.S.—400 Bks.

Spear Cavacelio

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77783

CERTIFICATE OF DEATH.

44 D77783

1-PLACE OF DEATH D77783 Registered No.

City of BALTIMORE: (No. Mercy Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mr. Spears Cavacelio

(a) Residence No. 2201 N. Fulton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1860.

7-AGE. 63 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None.

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Greece

PARENTS

10-NAME OF FATHER, Nick Cavacelis.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Greece

12-MAIDEN NAME OF MOTHER, Josephine.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Greece

11- (Informant) Hospital Record.

(Address)

13- JUL 25 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/23/23

17- I HEREBY CERTIFY, That I attended deceased from June 28 1923 to July 23rd 1923 that I last saw him alive on July 23rd 1923 and that death occurred, on the date stated above, at 10.15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach with metastasis to Omentum Liver + intestine

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of July 5-23

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) H. W. Dolby, M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, 19
20-UNDERTAKER.	ADDRESS

Commissioner Health. JUL 24 1923

Per. Wm. R. WOODALL

0529

229

N. B.—WRITE PLAINLY, with unfading ink. All items must be answered EXACTLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. If under one year, state in days. If under one day, state in hours or minutes. Occupation should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND

Spec.—1-10-21—M&T—1500 Blks.

(Dugustine) ✓

D77784 HEALTH DEPARTMENT—CITY OF BALTIMORE D77784

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

CITY OF BALTIMORE: No. St Agnes Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Dugustine

(a) RESIDENCE NO. 655 Lighter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: white | 5 Single, ~~Married, Widowed,~~ or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): July 16-1923

7 AGE: Years — | Months — | Days 6 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED: Child

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Samuel Dugustine

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Rosa Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant (Address): Raymond Dugustine 655 Lighter st

15 Filed ..... 19 ..... ROBERT N. KRAUTER, Registrar

JUL 25 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 1923

17 I HEREBY CERTIFY, That I attended deceased from July 16 1923 to July 22 1923 that I last saw h[illegible] alive on July 22 1923 and that death occurred, on the date stated above, at 4 30 A m.

The CAUSE OF DEATH* was as follows:

atelectasis

(duration) ..... yrs. ..... mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward A. Kudowski M. D.

19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincent Cemetery | DATE OF BURIAL: July 24 1923

UNDERTAKER: George F Rusch | ADDRESS: 735 Washington Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77785 D77785

CERTIFICATE OF DEATH. 114

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 N Pulaski ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Coats

(a) RESIDENCE NO. 515 N Pulaski ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/27/1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER William Coats

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Caroline Burton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Emma Pratt

(Address) 18 Kentucky Ave Atlantic City NJ

15 JUL 25 1923 ROBERT N. KRAUSE Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/22/1923

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1923, to July 22, 1923, that I last saw h[er] alive on July 22, 1923, and that death occurred, on the date stated above, at 6 8 m.

The CAUSE OF DEATH* was as follows:

Cerebral Exhaustion

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Acute Intestinal Catarrah (duration) yrs. 1 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Tompkins M. D.

(Address) 1019 Druid Hill ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL 7/26 1923

20 UNDERTAKER: Samuel Wesley

ADDRESS 1[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77786

CERTIFICATE OF DEATH.

188-003 D77786

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hosp. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Walter James Rainey

(Residence in Baltimore: No. 1712 McCulloh St.; yrs. 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Col'd

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH. Unknown (Month) (Day) 1 (Year)

7-AGE. 14 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Auto driver
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Va'

PARENTS.

10-NAME OF FATHER. S. Rainey

11-BIRTHPLACE OF FATHER, (State or Country). Va

12-MAIDEN NAME OF MOTHER. C Carter

13-BIRTHPLACE OF MOTHER, (State or Country). Va'

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam' Rainey

(Address) 1712 Mc Culloh

15-

BURIAL PERMIT ISSUED JUL 25 1923 ROBERT N. KRAUSE Registrar.

Burial Permit [illegible]

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 22 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to Accidental death on the day stated above.

The CAUSE OF DEATH* was as follows:

Concussion of brain and other injuries - Caused by automobile accident, or run over by (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

July 23 192.. (Address) 1616 Bway

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents). At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death*?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, July 25 1923.

20-UNDERTAKER, Samuel Thomley ADDRESS 578 W Baltimore

Spec.—8-24-14—M. & T.—2000 Bks.

Herbert H Paige

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77787 51 D77787

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woodyear 1660 ST.; (WARD) 6

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herbert H. Paige

(Residence in Baltimore: No. 1660 Woodyear St.; 1 yrs. 4 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct. 14, 1879 (Month) (Day) (Year)

7-AGE, 43 yrs. 9 mos. 8 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Cook

9-BIRTHPLACE, (State or Country), N.C.

PARENTS.

10-NAME OF FATHER, James Paige

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Flora Rambeau

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Paige

(Address) 1356 Woodyear St

15. JUL 25 1923 ROBERT R. KRAUTER, Burial Permit [illegible]er.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 22, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1923, to July 22 1923, that I saw h[illegible] alive on July 22 1923, and that death occurred, on the date stated above, at 7.30 p.m.

The CAUSE OF DEATH* was as follows: Acute Bronchitis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) General debility

(Duration) ..... yrs. 9 mos. ..... ds.

(Signed) W. T. Robertson M. D.

July 25 1923 (Address) 2037 McCulloh St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem. DATE OF BURIAL, July 25, 1923

20-UNDERTAKER Samuel T Hensley ADDRESS 539 Biddle

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77788 ✓ D77788

D77788

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH St Agnes Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ~~840 Brookline Ave~~ ST., WARD)

2-FULL NAME Miss Katherine Fahey

(a) RESIDENCE NO. 890 Linden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
66	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 837

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant (Address): Mrs. P. McNamee 2 E. Preston St

15 JUL 25 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 23 1923

17 I HEREBY CERTIFY That I attended deceased from July 7 1923, to July 23 1923, that I last saw her alive on July 23 1923, and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

Chronic nephritis

(duration) 2 yrs.? mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward H. Kettawahn, M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Patrick's Cemetery — DATE OF BURIAL: July 25 1923

20 UNDERTAKER: Mc. Mc. & S' Funeral — ADDRESS: 1787 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77789

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77789

CERTIFICATE OF DEATH

16-062

1-PLACE OF DEATH Nursery & Childs Hospital Franklin & Schroeder Sts.

REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Wm. Uhler -

(a) RESIDENCE NO. N. of C. Hosp. - ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~, (write the word)
Male -	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 11th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... None

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Eugen Uhler

11 BIRTHPLACE OF FATHER (city or town) ...
(State or country) Westminster Md

12 MAIDEN NAME OF MOTHER Thelma Zenglein

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) Westminster Md

14 Informant Thelma Uhler
(Address) 1926 Light St

15 JUL 25 1923 ROBERT N. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1923.

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1923, to July 24, 1923,

that I last saw him alive on July 24, 1923,

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Dysentery - bacillary -

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? ...

(Signed) Lawson Hilkins M. D.

July 24, 1923 (Address) 1014 St Paul St -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MOUNT OLIVET CEM

DATE OF BURIAL: 7/26 1923

20 UNDERTAKER: ROBERT BROOKS & SON

ADDRESS COR CALHOUN HOLLINS ST

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77790

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77790

113

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1034 S. Shay ST., ... WARD)

2-FULL NAME Mary E. Norton

(a) RESIDENCE NO. 1034 S. Shay ST., W B WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 16-23

7 AGE — Years: — Months: 6 Days: 9 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Norman E. Norton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Rosa V. Becker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Norman E. Norton 1034 S. Shay

15 Filed JUL 25 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 25 1923

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1923, to July 25, 1923

that I last saw h[illegible] alive on July 24, 1923

and that death occurred, on the date stated above, at 155a m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. E. Campbell M. D.

July 25, 1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 7/27 1920

20 UNDERTAKER: Wm Cook — ADDRESS: 502 C Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77791

HEALTH DEPARTMENT—CITY OF BALTIMORE (Phelps) ✓

D77791

CERTIFICATE OF DEATH. 1-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2nd Gen Hospital (Street) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benj Phelps. NB

(a) RESIDENCE No. St Helena Baltimore Co. (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. — mos. 4 ds. How long in U. S., if of foreign birth? NP yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Jones

6 DATE OF BIRTH (month, day, and year) Jan. 8 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) NO

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Phelps

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Lehany

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Rose Phelps

(Address) 340 Belair ave St Helena

15 Filed JUL 25 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-24-23

17 I HEREBY CERTIFY, That I attended deceased from 7-21-23 19 . to 7-24-23 19 ,

that I last saw him alive on 7-24-23 ,

and that death occurred, on the date stated above, at 6 40 p m.

The CAUSE OF DEATH* was as follows:

Typhoid.

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Anaemia, Cardiac Failure (duration) yrs. mos. ds.

Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical Symptoms

(Signed) Jno A Krug Jr M. D.

, 19 (Address) 2nd Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	July 27 1923

20 UNDERTAKER ADDRESS Wm Cook 502 E Mt St Co.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

· AFFIDAVIT ·

Spec.—1-10-21—M&T—1500 Bks.

D77792 HEALTH DEPARTMENT—CITY OF BALTIMORE D77792

44

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 403 N. 24th St ST., WARD) 7

2-FULL NAME Mary Rennie

(a) RESIDENCE NO. 403 N 24th ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Rennie

6 DATE OF BIRTH (month, day, and year) Nov 27 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Patrick Fennon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Kelly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thomas Rennie (Address) 403 N 24th St.

15 Filed JUL 25 1923 ROBERT N. KRAUTER, Registrar. Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25th 23

17 I HEREBY CERTIFY, That I attended deceased from Oct 3rd, 1923, to July 25th, 1923, that I last saw him alive on July 25th, 1923, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of No

Was there an autopsy? .....

What test confirmed diagnosis? X ray & Autopsy

(Signed) Geo Margetson M. D.

(Address) 401 E. 25 St City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dear Central Dec 28 1923

DATE OF BURIAL

20 UNDERTAKER H. M. Cook 602 E. Balto

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D77793

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7H-001 D77793

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 114 Regal St ST., WARD)

2-FULL NAME Mary B. Rents

(a) RESIDENCE NO. 114 Read St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frank Heyssy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frances P. Fenty
(Address) 114 Read St

15 Filed JUL 25 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 24 July 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) yrs. mos. ds.

(Signed) H B Jones M. D.
(Coroner.)

7-25, 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 27 1923
20 UNDERTAKER	ADDRESS
E. A. B. Slade	115 E West St

Initial blank to be signed EXACTLY. PHYSICIANS should take CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D77794 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D77794

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 Carroll St, Brooklyn ST., WARD)

2-FULL NAME William C. Howard

(a) RESIDENCE NO. 104 Carroll St. Brooklyn ST., 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Howard

6 DATE OF BIRTH (month, day, and year) June 7 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	43	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Fertilizer Mfg.

(c) Name of employer Standard Fertilizer Co

9 BIRTHPLACE (city or town) (State or country) Furnace Branch A.A.Co. Md.

PARENTS

10 NAME OF FATHER George Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) A.A.Co. Md.

12 MAIDEN NAME OF MOTHER Sarah Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Junc. Md.

14 Informant Ella Howard (Wife) (Address) 104 Carroll St. Brooklyn

15 JUL 25 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1923

17 I HEREBY CERTIFY, That I attended deceased from July 20th, 1923, to July 23rd, 1923, that I last saw him alive on July 22nd, 1923, and that death occurred, on the date stated above, at 10.30 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Mitral Regurgitation

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart

(duration) Minutes hrs. dys.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Harry Heckel M. D.

7/24, 1923 Address) 1224 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Furnace Branch A&Co — DATE OF BURIAL July 26, 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS SPACE FOR RECORDING DATA. AGE should be stated EXACTLY. PHYSICIAN should write mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77795 — 117 — D77795

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Provident Hospital ST.; 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane E. Robinson

(Residence in Baltimore: No. 1413 Argyle Av St. 35 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Jan. 29, 1874 (Month) (Day) (Year)

7-AGE, 49 yrs. 5 mos. 24 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)..... at home

9-BIRTHPLACE, (State or Country), D.C.

PARENTS.

10-NAME OF FATHER, Thomas H. Evans

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Alice V. White

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joshua R. Rougon Rhuebaus

(Address) 1413 Argyle Ave

15- Filed JUL 25 1923 ROBERT R. KRAMES Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH July - 23, 1923 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from July 16 1923, to July 23 1923, that I saw h[illegible] alive on July 23 1923, and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Suppurative Appendicitis

(Duration) 1 yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Peritonitis

(Duration) yrs. 7 mos. ds.

(Signed) S. B. Hughes M. D.

July 24 1923 (Address) 1413 Argyle Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 7 ds. In the State 35 yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 1413 Argyle Ave

Former or usual residence "

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn Cemetery — DATE OF BURIAL. July 27, 1923

20-UNDERTAKER John M. Johnson — ADDRESS 309 Druid Hill Ave.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77796

CERTIFICATE OF DEATH.

113 D77796

1-PLACE OF DEATH

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 520 N. Gilmor St., WARD)

2-FULL NAME Joseph Gunter

(a) RESIDENCE No. 520 N. Gilmor St., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., If of foreign birth? yrs. 1 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		1	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Edward Smith

11 BIRTHPLACE OF FATHER (city or town) Suburn
(State or country)

12 MAIDEN NAME OF MOTHER Maggie Gunter

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Maggie Gunter
(Address) 520 N. Gilmor St.

15 Filed JUL 25 1923 192 Robert P. Harrison,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death
on the day stated above.
The CAUSE OF DEATH* was as follows:

Sclerema

(duration) ... yrs. ... mos. 1 ... ds.

CONTRIBUTORY (Secondary) Congenital

(duration) ... yrs. ... mos. ... ds.

(Signed) C. J. Kenney, M. D.
(Coroner.)
July 25, 192 (Address) 2 E. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	192
20 UNDERTAKER	ADDRESS

Commissioner of Health
Per Wm. F. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77797

CERTIFICATE OF DEATH.

113 D77797

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 520 N. Gilmor St., WARD 10)

2-FULL NAME Baby Gunter

(a) RESIDENCE No. 520 N. Gilmor St., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31, 192[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		1	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) Infant
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Edward Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lebanon

12 MAIDEN NAME OF MOTHER Maggie Gunter

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Maggie Gunter
(Address) 520 N. Gilmor St.

15 Filed JUL 25 1923, 192 Robert P. Harrison,
Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 192[illegible]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry
(Inquest, autopsy or inquiry.)
find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronco-enteritis

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) no history

(duration) ... yrs. ... mos. ... ds.

(Signed) [illegible] M. D.
(Coroner.)

July 24, 192[illegible] (Address) 2802 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL ... 192[illegible]

20 UNDERTAKER Commissioner Health.

ADDRESS JUL 23 1923

For Wm. F. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77798

CERTIFICATE OF DEATH.

X 179

D77798

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., ... WARD)

2-FULL NAME Joseph L. Durligen

(a) RESIDENCE NO. Laurel Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	42	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B & O R R Co

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Jos Durligen

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Ogle

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Emil Durligen
(Address) Laurel Md

15 Filed 1-25 1923 Robert F. Bernhardt Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Pneumonia Influenza
Burns on body
(duration) yrs. mos 14 ds.
CONTRIBUTORY (Secondary) Accidentally Scalded
(duration) yrs. mos. ds.

(Signed) H H Gould M. D.
(Coroner)
(Address) Laurel Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 1/26 1923

20 UNDERTAKER H. J. Lahey Laurel

ADDRESS 31 E Eighth

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D77799

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77799

CERTIFICATE OF DEATH.

10

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital St., WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Robert Disney

(a) RESIDENCE NO. 5306 Dunmore Ave St., 27 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 3 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 24. 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Clarence L. Disney.

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Estelle Hair

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant B. Macgowan. M.D. (Address)

15 Filed [redacted] P. Harrison, Registrar

JUL 25 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/24 1923

17

I HEREBY CERTIFY, That I attended deceased from 7/8, 1923, to 7/24, 1923,

that I last saw him alive on 7/24, 1923,

and that death occurred, on the date stated above, at 5.24 P.m.

The CAUSE OF DEATH* was as follows:

Laryngeal diphtheria

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Septicaemia (Streptococcus viridans)

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? 5306 Dunmore Ave. City

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pos. K.L.6 + Streptococcus viridans

(Signed) B. Macgowan, M. D.

7/24. 1923 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dove Chapple — DATE OF BURIAL: July 25 '23

20 UNDERTAKER: A. S. Marshall — ADDRESS: 3639 Falls Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ANTECEDENT CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77800

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77800

CERTIFICATE OF DEATH. X 129

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) St Agnes Hospital ST., (WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Vincent

(a) RESIDENCE NO. Greensboro NC ST., WARD Greensboro N. Ca
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: 35t.
4 COLOR OR RACE: white
5 Single, ~~Married, Widowed,~~ or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	—	—	—

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer): 870
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Not Known

PARENTS
10 NAME OF FATHER: Not Known
11 BIRTHPLACE OF FATHER (city or town) (State or country): " "
12 MAIDEN NAME OF MOTHER: Not Known
13 BIRTHPLACE OF MOTHER (city or town) (State or country): " "

14 Informant (Address): Sisters of Charity St Agnes Hospital

15 Filed ..., 19... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 25 1923

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1923, to July 25, 1923, that I last saw her alive on July 25, 1923, and that death occurred, on the date stated above, at 1250 Am. m.

The CAUSE OF DEATH* was as follows:
Anaemia
Chronic nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of
Was there an autopsy? —
What test confirmed diagnosis?

(Signed) Edward H Kidenokij, M. D.
, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: July 27 1923
20 UNDERTAKER: Martin Lakey & Son — ADDRESS: 837 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS STATEMENT SHOULD BE MADE EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77801

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77801

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospt St., N (WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ellen Lyons

(a) RESIDENCE NO. St Agnes Hospt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant St Agnes Hospt (Address)

15 Filed , 19 [redacted] F. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23rd 1923

17

I HEREBY CERTIFY, That I attended deceased from April 12 , 1918 , to July 23rd , 1923.

that I last saw her alive on July 23 , 1923

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

myo-carditis,

(arterio-sclerosis)

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Edward A. Kotowski , M. D.

, 19 Address St Agnes Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL July 26 1923

20 UNDERTAKER Martin Fahey & Son — ADDRESS 1827 W North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

D77802

CERTIFICATE OF DEATH

D77802

REGISTERED NO. C .....

1 PLACE OF DEATH Kernan Hospital.

CITY OF BALTIMORE (No. Hillsdale Catonsville Md. ST.: ..... WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary Luciano.

(Residence in Baltimore: No. 403 N Stricker st ..... St.: 3 yrs. 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
Female.	white	child soc.

6 DATE OF BIRTH: May 3, 1918 (Month) (Day) (Year)

7 AGE: 5 yrs. 2 mos. 22 ds. | If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: child 5 yrs
(b) General nature of industry, business, or establishment in which employed (or employer): Age -

9 BIRTHPLACE (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Joseph Luciano

11 BIRTHPLACE OF FATHER (State or country): Italy

12 MAIDEN NAME OF MOTHER: Adalina Carletti.

13 BIRTHPLACE OF MOTHER (State or country): Italy.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) mrs Adalina Luciano

(Address) 403 N. Stricker st Balto

15 Robert F. Harrison,
Filed ....., 191 Burial Permit Clerk. REGISTRAR

UL 25 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July 24, 1923 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st, 1923, to July 24 1923, that I saw h-- alive on July 24, 1923 and that death occurred, on the date stated above, at 12:20 P m.
The CAUSE OF DEATH* was as follows:

Bronco-
Pneumonia

4 days - (Duration) ..... yrs. ..... mos. 18 ds

Contributory (SECONDARY) Peritonitis

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) Benjamin Tappan M. D.

July 25, 1923 (Address) 402 N. Charles St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. 27 ds. In the State 3 yrs. 7 mos. ..... ds.

Where was disease contracted, if not at place of death? Origin of cancer not known

Former or usual residence 403 Stricker St.

19 PLACE OF BURIAL OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: July 26, 1923

20 UNDERTAKER: John Merrick ADDRESS: 2008 Aliceanna

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY. WITH UNFADING INK — THIS IS A PERMANENT RECORD

D77803 HEALTH DEPARTMENT—CITY OF BALTIMORE D77803

CERTIFICATE OF DEATH. 164

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 115 N. Montford Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Stevenson

(Residence in Baltimore: No. 1507 Holbrook St. St.; yrs. 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	widow

6-DATE OF BIRTH, Jan 8/1857 (Month) (Day) (Year)

7-AGE	If LESS than 1 day,
76 yrs. 6 mos. 16 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Ohio

PARENTS.

10-NAME OF FATHER, Thomas E. Barlow

11-BIRTHPLACE OF FATHER, (State or Country). England

12-MAIDEN NAME OF MOTHER, Susan Smith

13-BIRTHPLACE OF MOTHER, (State or Country). England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry T. Stevenson

(Address) 1507 Holbrook St.

15- Filed JL 25 1923 192.... Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 24/23 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Asthenia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) J. S. H. Haller M. D. (Coroner.)

7/25/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Mount Carmel Cem	July 28 1923
20-UNDERTAKER, John Bellrist	ADDRESS 2008 Orleans

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77804

CERTIFICATE OF DEATH.

113

D77804

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1449 Reynold ST., WARD)

2-FULL NAME John Jaworski

(a) RESIDENCE NO. 1449 Reynold ST., WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 10 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Joseph Jaworski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Josephine Pancyzsk

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Joseph Jaworski

(Address) 1449 Reynold St

Filed JUL 25 1923, 19.....

Robert P. Garrison,
Burial Permit Clerk.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1923

17 I HEREBY CERTIFY, That I attended deceased from July 16 - 1923, to July 20 1923, that I last saw him alive on July 20th 1923 and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis

(duration) ..... yrs. mos 14 ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical facts -

(Signed) L Krosh, M. D.

July 25, 1923 (Address) 2202 W North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 26 1923
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank

P.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

165081
D77805

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77805

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH Johns Hopkins Hospital.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Edmond Kedzior.

(a) RESIDENCE NO. 1610 Gough St., ST., 15 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 9 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 4 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (Child)

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Stanislaus Kedzior

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Sobus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant ..... (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 25 1923 19 ..... Robert F. Haviland Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1923.

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1923. to July 24, 1923. that I last saw him alive on July 24, 1923, and that death occurred, on the date stated above, at 9.15 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) 0 yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) Mongolian idiocy; Congenital cardiac disease.

(duration) yrs. 9 mos. 10 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? yes Date of July 16, 1923

Was there an autopsy? no

What test confirmed diagnosis? Condition of lungs. Culture of pneumococcus from blood.

(Signed) William H. F. Barthan, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL July 26 1923

20 UNDERTAKER John McWeber

ADDRESS 803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

164063, D77806

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77806

CERTIFICATE OF DEATH. X 71-001

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST., ... WARD) 7

2-FULL NAME Robert Propst.

(a) RESIDENCE No. Concord, N.C. R#5 ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11m 9ms. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) January 1912

7 AGE — Years: 11 — Months: — — Days: — — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Concord N.C

PARENTS

10 NAME OF FATHER W. C.

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant .....

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 25 1923 . 19 .. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1923, to July 25, 1923, that I last saw him alive on July 25, 1923, and that death occurred, on the date stated above, at 6.48 A m.

The CAUSE OF DEATH* was as follows:

Meningitis- (Pneumococcus)

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Brain abscess

(duration) ..... yrs. 2 mos. 15 ds.

18 Where was disease contracted if not at place of death? Concord N.C.

Did an operation precede death? Yes Date of June 1-5?

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy - Culture

(Signed) Warfield M Theobald M. D.

7/25 1923 (Address) J. H Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Concord N.C.

DATE OF BURIAL July 25 1923

20 UNDERTAKER Joseph Abrens

ADDRESS 224 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be particular in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77807

CERTIFICATE OF DEATH.

114 D77807

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 N. Bond ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Moses Hill

(Residence in Baltimore: No. 509 N. Bond St.; 18 yrs., mos., da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the)
M	C	Married

6-DATE OF BIRTH, July (Month) ..., 1905 (Year)

7-AGE, 32 yrs. mos. 5 da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), S. C.

PARENTS.

10-NAME OF FATHER, Henry Hill

11-BIRTHPLACE OF FATHER (State or Country), S. C.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Essie Wilson

(Address) 127 N. Central Ave

15-

Filed JUL 26 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 24, (Day) 1923 (Year)

I HEREBY CERTIFY, That I attended deceased from July 21 1923, to July 24 1923, that ~~I saw~~ he was alive on July 24 1923, and that death occurred, on the date stated above, at 1.15 p.m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(Duration) ...yrs. ...mos. 5 da.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...da.

(Signed) R J Young M. D.

7/24, 1923. (Address) 1129 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Gastonia N. C. DATE OF BURIAL, July 26, 1923

20-UNDERTAKER J. L. Brown & Son ADDRESS 108 W. Montgomery

B. & O. R.R. & Main Line Southern

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77808
1-PLACE OF DEATH

CERTIFICATE OF DEATH. X 100-001 D77808

Registered No. C.....

City of BALTIMORE: (No. 801 N. Rutland Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George F. Briggs

(Residence in Baltimore: No. 801 N. Rutland Ave St.; yrs., 6 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	col	S

6-DATE OF BIRTH. March 3/1922
(Month) (Day) (Year)

7-AGE. 1 yrs. 4 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Smithfield Va.

PARENTS.

10-NAME OF FATHER. Robert Briggs

11-BIRTHPLACE OF FATHER, (State or Country). Smithfield Va.

12-MAIDEN NAME OF MOTHER. Didy Booze

13-BIRTHPLACE OF MOTHER, (State or Country). Smithfield Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Didy (Booze) Briggs

(Address) 801 N. Rutland Ave.

15 JUL 26 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 25/23
(Month) (Day) (Year) 192...

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ...yrs. ...mos. 14 ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

(Signed) J. S. H. Fuller M. D.
(Coroner.)

7/25/23 192 (Address) 508 E. North Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence Smithfield Va

19-PLACE OF BURIAL OR REMOVAL. Mt Auburn Cemetery DATE OF BURIAL. July 26 1923

20-UNDERTAKER, Edward Bryson ADDRESS 1631 Orleans St

Spec.—1-10-21—M&T—1500 Blks.

1642980 HEALTH DEPARTMENT--CITY OF BALTIMORE 113 D77809

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) John Hopkins Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary H. Heatly. (Mary H. Heatly)

(a) RESIDENCE NO. 2129 Taylor St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. unknown ds. How long in U. S. if of foreign birth? yrs. 3 mos. 25 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 29, 1923.

7 AGE — Years: — Months: 5 Days: 25. If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baby.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Willard Heatly.

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.Y.

12 MAIDEN NAME OF MOTHER: Anna Powers.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): JOHNS HOPKINS HOSPITAL.

15 Filed JUL 26 1923 By ROBERT R. KRAUTH, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1923. to July 25, 1923. that I last saw her alive on July 25, 1923, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Otitis Media, Acute.

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary) Diarrhoea (not dysentery)

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Horton Casparis M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Near Cathedral Cemetery — DATE OF BURIAL: July 26 1923

20 UNDERTAKER: Henry Knecht Son — ADDRESS: 1301 E. Eager St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77810 D77810

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Mercy Hospital St., Ward)

2-FULL NAME Jno. A Thompson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 1942 Hanover St.; yrs. 50 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1..... (Year)

7-AGE: 62 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Machinist
(b) General nature of Industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Va.

PARENTS.

10-NAME OF FATHER: Jno. Thompson

11-BIRTHPLACE OF FATHER, (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Mary Bischell

13-BIRTHPLACE OF MOTHER, (State or Country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Thompson

(Address) 1942 Hanover

15- JUL 26 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 26 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Sudden (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Paralysis Edema

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner.)

July 26 1923 (Address) 1634 Bruce

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State 4 yrs 11 mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Loudon Hill Cem. DATE OF BURIAL, 7/28 1923

20-UNDERTAKER, E & B Harlow ADDRESS 1100 West St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77811

CERTIFICATE OF DEATH.

74-001 D77811

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 Madison Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary D.C. McClellan

(a) RESIDENCE NO. 1208 Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm W. McClellan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Maria Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Wm J. McClellan (Address) 1208 Madison Ave

15 JUL 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1922, to July 24 1923.

that I last saw h alive on July 23 1923

and that death occurred, on the date stated above, at 12.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm F. Lockwood, M. D.

, 19 (Address) 8 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Presb Cem

DATE OF BURIAL 7-27 1923

20 UNDERTAKER Henry W. Rubins & Sons Co

ADDRESS McCulloh Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77812 — CERTIFICATE OF DEATH. X 36-004 — D77812

1-PLACE OF DEATH Hospital for the Women of Maryland — REGISTERED NO.

CITY OF BALTIMORE: (No. John & Lafayette ST. ? WARD 7)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Jean Young Currie

(a) RESIDENCE NO. Effington Rd. Mt. Washington, ST. Md, WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 29, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Vocal teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Smith College North Hampton, Mass.

(c) Name of employer

9 BIRTHPLACE (city or town) Milwaukee
(State or country) Wisconsin

PARENTS

10 NAME OF FATHER James Currie

11 BIRTHPLACE OF FATHER (city or town) Eyr
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Jean A. Harper

13 BIRTHPLACE OF MOTHER (city or town) Milwaukee
(State or country) Wisconsin

14 Informant Mrs. Hew. Draper (Sister)
(Address) Effington Rd. Mt. Washington Md.

15 Filed JUL 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1923, to July 25, 1923, that I last saw her alive on July 25, 1923, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 hrs.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 25, 1923.

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination

(Signed) J. Ogle Mayfield, Jr. M. D.

, 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Milwaukee Wis.	July 26 1923
20 UNDERTAKER Henry Wenkin & Son	ADDRESS Orchard & Collington

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77813

CERTIFICATE OF DEATH.

100-001 D77813

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Pearce

(a) RESIDENCE No. 440 Fawcett St ST., 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Unknown ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown ?

12 MAIDEN NAME OF MOTHER Unknown ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown ?

14 Informant Municipal Hospital Records.

(Address)

15 Filed JUL 26 1923 ROBERT N. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24, 1923

17

I HEREBY CERTIFY, That I attended deceased from January 25, 1922 to July 24, 1923.

that I last saw her alive on July 24, 1923,

and that death occurred, on the date stated above, at 2:35 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Arthritis

Arteriosclerosis + Hypertension

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (Terminal) (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Goldsmith M. D.

7-25-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	July 26/23
20 UNDERTAKER CHERROWETH & SON, 3617 CHESTNUT AVE.	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77814

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

70 D77814

REGISTERED NO.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lawson & Green ST. S WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Hilda Klein

(a) RESIDENCE NO. 572 University parkway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WHITE PLAINLY, WITH ORDINARY PENCIL. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 29, 1908

7 AGE Years 14 Months 11 Days 25 If LESS than 1 day, ...hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Rudolph Klein

11 BIRTHPLACE OF FATHER (city or town) N. J. (State or country)

12 MAIDEN NAME OF MOTHER Gertrude Seward

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Rudolph W. Klein (Address) 572 Westmoreland Parkway

15 JUL 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-24 1923

17

I HEREBY CERTIFY, That I attended deceased from 7-16, 1923, to 7-24, 1923

that I last saw her alive on 7-24, 1923

and that death occurred, on the date stated above, at 9:55 a.m.

The CAUSE OF DEATH* was as follows:

Encephalitis septic

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Brain abscess (right side)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-16-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) R. Dyer, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL July 26 1923

20 UNDERTAKER John O'Mitchell — ADDRESS 1201 W. Fayette St

Cor.—1-12-23—M&T—100 Bks.

Gill

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77815

CERTIFICATE OF DEATH.

90 D77815

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 233 N. Amity St., WARD)

2-FULL NAME Ann E Gill

(a) RESIDENCE NO. 221 N. Amity St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colr	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant Ann Farley
(Address) 928 N Fayette St

15 JUL 26 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) Geo Gill find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of the Heart

(duration) yrs. Dont Know mos. ds.

CONTRIBUTORY (Secondary) Dont Know

(duration) yrs. mos. ds.

(Signed) D K Gonahy M. D.
(Coroner)

July 25 1923 (Address) 1117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 7-26 1923

20 UNDERTAKER Daniel Easton — ADDRESS 916 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77816

CERTIFICATE OF DEATH.

124

D77816

1-PLACE OF DEATH Colonial Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1122 N. Mount ST., WARD)

2-FULL NAME Charles Hattie

(a) RESIDENCE NO. 413 Moore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Entire life ds. How long in U.S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
37				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Richard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary Brash

(Address) 413 Moore St. City

15 Filed JUL 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 - 1923

17 I HEREBY CERTIFY, That I attended deceased from July 20th, 1923, to July 23, 1923, that I last saw him alive on July 23rd, 1923, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Liver Abscess

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis.

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. P. Robinson M. D.

, 19 (Address) Colonial Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int Auburn Cem

DATE OF BURIAL 7-26 1923

20 UNDERTAKER Daniel Easters

ADDRESS 916 Dames

N. B.—WHITE PAPER, WITH CANARY BORDER. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates. OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77817

CERTIFICATE OF DEATH.

74-001 D77817

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 206 Ostenstein ST., WARD)

2-FULL NAME Bettie Johnson

(a) RESIDENCE NO. 206 Ostenstein ST., WARD 21

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. Unknown ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Johnson

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housework 7/10 d/o

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Hammond

(Address) 222 Ostenstein St

15 Filed JUL 26 1923 ROBT. N. KRAUTER, Burial Permit [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/25/1923

17 I HEREBY CERTIFY, That I attended deceased from 7/24/1923, to 7/25/1923, that I last saw h[illegible] alive on 7/24/1923, and that death occurred, on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Arthrio-sclerosis

Unknown (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? No. —

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) J. Guy Bowley, M. D.

7/25/23 (Address) 908 N. Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Marks Cem. DATE OF BURIAL 7-28-1923

20 UNDERTAKER Daniel Easton ADDRESS 916 Gay

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77818

CERTIFICATE OF DEATH.

151 D77818

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 578 Druid Hill Ave ~~ST.~~ WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Hailstock

(a) RESIDENCE NO. 578 Druid Hill Ave ~~ST.~~ WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Wm Hailstock

6 DATE OF BIRTH (month, day, and year) June 4, 1861

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
62	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Princess Anne (State or country) Md

PARENTS

10 NAME OF FATHER Edward Jones

11 BIRTHPLACE OF FATHER (city or town) Princess Anne (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Handy

13 BIRTHPLACE OF MOTHER (city or town) Princess Anne (State or country) Md

14 Informant Annie Jones (Address) 413 W. Cullob St

15 Filed ..., 19 ... Registrar

JUL 26 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24. 1923

17 I HEREBY CERTIFY, That I attended deceased from July 21st, 1923. July 24th 1923.

that I last saw her alive on July 24th, 1923.

and that death occurred, on the date stated above, at 3:05 a. m.

The CAUSE OF DEATH* was as follows:

Tongue of foot

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (secondary) Debility due to chronic Nephritis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. La Lane, M. D.

7-24. 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem

DATE OF BURIAL 7-27 1923

20 UNDERTAKER Daniel Easton

ADDRESS 914 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D77819

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X/29 D77819

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2526 Keyworth Ave St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Belle Bump

(a) Residence No..... Philadelphia St. Pa Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. — ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 28-1865

7-AGE,	If LESS than 1 day,
58 yrs. 5 mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Josephus L. Bump

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Mass.

12-MAIDEN NAME OF MOTHER, Wilderman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md.

14- (Informant) Fred K. Brown

(Address) 2526 Keyworth

JUL 26 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 20-1923

17- I HEREBY CERTIFY, That I attended deceased from July 9, 1923, to July 25, 1923 that I last saw her alive on July 25, 1923 and that death occurred, on the date stated above, at 12 1/2 a. m.

The CAUSE OF DEATH* was as follows:

Ch. Nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Probably Phila. Pa.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Mpsc - Chemical

(Signed) Wm. Dulany Thomas, M. D.

July 25, 1923 (Address) 330 E. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Druid Ridge	July 26, 1923
20-UNDERTAKER,	ADDRESS
William Cook	502 E. North

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77820 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D77820

CERTIFICATE OF DEATH. 6424

1-PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard Green ST., S WARD) 4

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah A. Green

(a) RESIDENCE NO. New Windsor ST., Maryland WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced (or) WIFE of Lewis Green

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph. Bail

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Fanny Flickinger

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Hospital records.

(Address)

15 JUL 26 1923 ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-26 1923

17 I HEREBY CERTIFY, That I attended deceased from 7-6, 1923, to 7-26, 1923

that I last saw her alive on 7-26, 1923

and that death occurred, on the date stated above, at 4:35 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cholecystitis (suppurative) Stone in Cystic duct. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7-9-23

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) [illegible], M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dulaney Valley Memorial Park DATE OF BURIAL July 27 1923

20 UNDERTAKER L. M. Mudd ADDRESS Mayfield Md.

N. B.—WRITE PLAINLY, WITH INDELIBLE PENCIL. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77821

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 100-001 D77821

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Conaly Freeman

(a) RESIDENCE No. Pikesville Md- ST., WARD 4

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 2, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Smith County
(State or country) Virginia

PARENTS

10 NAME OF FATHER Eli Freeman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Smith Co- Virginia

12 MAIDEN NAME OF MOTHER Margaret Lewis

13 BIRTHPLACE OF MOTHER (city or town) Smith Co,
(State or country) Virginia

14 Informant Eli Freeman
(Address)

15 Filed JUL 26 1923 ROBERT R. KRAUSE
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 19 23

17

I HEREBY CERTIFY, That I attended deceased from July 19, 19 23, to July 25, 19 23,
that I last saw him alive on July 25, 19 23,
and that death occurred, on the date stated above, at 9:05 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Bronchopneumonia

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms & signs

(Signed) B. McAbee, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Glenwood Grave Co.	7/27 1923
UNDERTAKER	ADDRESS
Frank Poole	115 E West St

MAKE ENTRIES WITH PEN AND INK. NAME should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Susie J. Knight

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77822

D77822

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 15 05 Hunter ST., WARD 15)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susie J. Knight.

(a) RESIDENCE NO. 15 05 Hunter ST., WARD

(Usual place of abode) (If non-residents give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write this word)
F	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Knight.

6 DATE OF BIRTH (month, day, and year) June 6, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
30	30	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Tight Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Annie Feeney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Wm West

(Address) 727 Baker W

15 JUL 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/24 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/20, 1923, to 7/24, 1923.

that I last saw her alive on 7/23, 1923.

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burkhart, M. D.

7/27 1923 (Address) 1139 Dolphin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 7/28 1923

20 UNDERTAKER Robert F. Weishaar

ADDRESS Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS PARTICULARLY NECESSARY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77823

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D77823

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1630 N Wolfe Street ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas L. Hilt

(a) RESIDENCE. No. 1630 N Wolfe St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ammand J. Hilt

6 DATE OF BIRTH (month, day, and year) May 11, 1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Charles W. Hilt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Todtsen

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Leroy Hilt
(Address) 1630 N Wolfe St.

15 Filed JUL 26 1923 19 ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15 1923, to July 25 1923, that I last saw him alive on July 25 1923, and that death occurred, on the date stated above, at 2-55 P m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation -

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart,

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ni Date of

Was there an autopsy? ni

What test confirmed diagnosis? X Ray.

(Signed) E. Gill Wall, M. D.

July 26 1923 (Address) 1631 E. North av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 7/28 1923

20 UNDERTAKER: Albert L Hilt Jr — ADDRESS: 1606 N Chester St

Should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should he used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may he indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

Spec.—1-10-21—M&T—1500 Blks.

164471 D77824 HEALTH DEPARTMENT—CITY OF BALTIMORE D77824

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Williams

(a) RESIDENCE NO. Chestnut Hill Ave. St. Elizabeth Home. ST., WARD 9

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 12, 1923

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	12.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Williams.

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Manne ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed JUL 26 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1923, to July 24, 1923, that I last saw her alive on July 24, 1923, and that death occurred, on the date stated above, at 9 20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2+ mos. ds.

CONTRIBUTORY (Secondary) Multiple Abscesses of skin (Tbc)

(duration) yrs. mos. 20+ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL July 26 1923

UNDERTAKER Pierce Collins & Boyle — ADDRESS Carey

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77825 D77825

CERTIFICATE OF DEATH.

74-002

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mount Hope Retreat ST.: 28th WARD: 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maurice Gloster

(a) RESIDENCE. NO. Mt Hope Retreat ST. 28th WARD.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? Lifetime yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	63	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Laboring.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) (?) Ireland

PARENTS

10 NAME OF FATHER Thomas M. Gloster

11 BIRTHPLACE OF FATHER (city or town) Kerry Co (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Brennan

13 BIRTHPLACE OF MOTHER (city or town) Co Kerry (State or country) Ireland

14 Informant (Address) Records of Mt Hope Retreat Baltimore Md

15 Filed JUL 26 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 5th 1893 to July 24, 1923, that I last saw h[illegible] alive on July 24, 1923, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism -

abt (duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary) Dipr. Psychosis -

abt (duration) 20 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J. Flanney, M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	July 27 1923

20 UNDERTAKER Lilly - Zeien ADDRESS 4008 Woodland

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77826

D77826

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 N Lakewood Ave ST.) (WARD 10)

2-FULL NAME Rosetta Lavinia Forsell

(a) RESIDENCE. NO. 125 N Lakewood Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20, 1923

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John W. S. Forsell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Etta V. Cummings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs. John W. S. Forsell
(Address) 125 N. Lakewood Ave

15 Filed July 27, 1923 Robert F. harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1923 to July 21, 1923

that I last saw h[illegible] alive on July 21, 1923

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth
(Not maturing)
Mother Nephritis

(duration) — yrs. — mos. 0 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. L. Shepard, M. D.

(Address) 3100 Abell Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 27 1923

20 UNDERTAKER ADDRESS

A. Sander & Sons 1710 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OAK SIDE

D77827 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77827

CERTIFICATE OF DEATH.

170

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 2120 Bank St. Ward)

2-FULL NAME... William Krieg

(Residence in Baltimore: No. 2120 Bank)

W (If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Wife ...st.; yrs.... mos.... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. Sept 25 1847
(Month) (Day) (Year)

7-AGE. 75 yrs. 9 mos. 29 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Pete Krieg

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jennie Krieg
(Address) 2120 Bank St

15- Robert F. Harrison,
Filed.....192..... Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 24 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to ...death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage Brain
Shot Self in Head — Suicide

CONTRIBUTORY (Secondary)..... (Duration) ...yrs. ...mos. ...ds.

(Signed) H. H. Horton M. D.
(Coroner)
July 25 1923 (Address) Curtis Bay, Balto.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Oak Lawn Cem. July 28 1923

20-UNDERTAKER. ADDRESS
H. Sander Sons 1710 Mad St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

D77828

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77828

CERTIFICATE OF DEATH.

162

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Blake

(a) RESIDENCE NO. Reisterstown Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-21-23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) Not known (State or country)

12 MAIDEN NAME OF MOTHER Mary Blake

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant .....
(Address) Robert F. Harrison, (JOHNS HOPKINS HOSPITAL,

15 Filed ..... 19 ..... Burial Permit Clerk Registrar

UL 26 1923

0.29

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 23 1923

17

I HEREBY CERTIFY, That I attended deceased from July 21, 1923, to July 23, 1923, that I last saw him alive on July 23, 1923, and that death occurred, on the date stated above, at 1 50 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

..... (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Louis H. Douglass, M. D.

7-23, 1923 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. ADDRESS .....

Wm. E. WOODALL JUL 26 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every question should be stated EXACTLY. PHYSICIAN should write legibly. Information should be carefully supplied. AGE should be stated in years, months and days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONTRIBUTORY CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—3-10-21 M&T 1500 Bks.

D77829

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77829

CERTIFICATE OF DEATH.

162

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Daris Grubbs

(a) RESIDENCE NO. Catonsville, Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 16-23

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Robt. Grubbs.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Kemptown, Md

12 MAIDEN NAME OF MOTHER Mary Porter.

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Martinsburg W. Va.

14 Informant Hospital Records
(Address)

15 Filed ..... 19 ..... Registrar Robert F. Norris

JUL 26 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1923

17

I HEREBY CERTIFY, That I attended deceased from July 16, 1923, to July 26, 1923, that I last saw her alive on July 26, 1923, and that death occurred, on the date stated above, at 12-45 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic Pneumonia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) S. Bleyer, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL July 25 1923

20 UNDERTAKER Harry H. Witzke — ADDRESS 1531 W Lombard

IMPORTANT: Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77830 D77830

CERTIFICATE OF DEATH. 159-003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 Garrison La ST., 20 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norma Cleffler

(a) RESIDENCE No. 307 Garrison Lane ST., 20 WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. 7 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): July 7 - 1923

7 AGE: Years ... Months ... Days 7 ... If LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Edward L. Cleffler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co Md

12 MAIDEN NAME OF MOTHER: Rose Kaye

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Brown Co Ill

14 Informant: Edna L Cleffler

(Address) 307 Garrison La

15 Filed ... 19 ... Robert F. Harrison, Registrar

Burial Permit Clerk.

JUL 26 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/25 1923

17 I HEREBY CERTIFY, That I attended deceased from 7/17 1923 to 7/25 1923

that I last saw her alive on 7/25 1923

and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Meningitis + Malnutrition

(duration) ... yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Hydrocephalus Spina-bifida Congenital Deformity (duration) ... yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? None

What test confirmed diagnosis? Physical Signs

(Signed) Green + Kelly M. D.

7/26 1923 (Address) 3705 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park DATE OF BURIAL July 26 1923

20 UNDERTAKER: George L Schwab ADDRESS 2101 Eutaw St

IMPORTANT—WRITE PLAINLY, WITH LEAD PENCIL. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D77831

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77831

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH Colonial Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 1122 N. Mount ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Welsh

(a) RESIDENCE No. 405 N. High ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5-2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single-Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	5-2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Michael Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Holmes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Joseph Welsh 1122 N Fulton Ave

JUL 26 1923

Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1923

17

I HEREBY CERTIFY, That I attended deceased from July 23, 1923, to July 25, 1923, that I last saw him alive on July 25, 1923, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma, probably involving structures in left ankle Ferrul Metastatic Carcinoma

(duration) yrs. 2½ mos ds.

CONTRIBUTORY (Secondary) Heart Disease inadequacy

(duration) yrs. mos. ds.

18 Where was disease contracted - if not at place of death? Not to my belief

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) J. P. Robinson, M. D.

, 19 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Woodlawn July 27 1923

20 UNDERTAKER — ADDRESS

Wm Cook Sons E. Monument Ave

...AGE should be stated EXACTLY. PHYSICIAN should state ...mation should be carefully supplied. AGE should be stated ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77832 — CERTIFICATE OF DEATH. 118-001 — D77832

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidie E. N. Hirshberg

(a) RESIDENCE. No. 1807 Madison ave. WARD

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4yrs yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie J. Hirshberg

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant.

(b) General nature of industry, business, or establishment in which employed (or employer) Paints

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Nathan Hirshberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jacob Hornstein

(Address) Eutaw Pl & Redwood st

15 Filed . 19 Robert P. Harrison. Registrar

UL 26 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1923

17 I HEREBY CERTIFY, That I attended deceased from July 19. 1923. to July 26. 1923. that I last saw h im alive on July 26. 1923. and that death occurred, on the date stated above, at 10. AM p.m.

The CAUSE OF DEATH* was as follows:

Paralytic Ileus.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 15 hrs

18 Where was disease contracted if not at place of death? 1) Residence 7/19/23 2) Hebrew Hosp. 7/23/23

Did an operation precede death? Yes Date of July 19, 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) A. Rodger Sandheimer M. D.

. 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	7/27 1923

20 UNDERTAKER ADDRESS

Johnson & Co 1611 Madison

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77833 ✓ D77833

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 335 Stinson ST.; WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Sylvester Burns

(a) RESIDENCE. No. 335 Stinson ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Mar. 11-1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	4	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stripping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Ernest E. Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Homer Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Howard Burns

(Address) 335 Stinson St

15 Filed JUL 26 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-24-1923

17 I HEREBY CERTIFY, That I attended deceased from July 9- 1923. to July 24. 1923.

that I last saw him alive on July 24. 1923.

and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

2 2 (duration) yrs., mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Date of

Was there an autopsy? ✓

What test confirmed diagnosis? Clinical

(Signed) E Keller Hemming M. D.

7/25. 1923 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	July 27 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1003½ Bl St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should s... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77834

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 107-003 D77834

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1841 Mc Henry ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert C. Maddox

(a) RESIDENCE NO. 1841 Mc Henry ST., 10 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 9 mos. 24 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie M. Maddox

6 DATE OF BIRTH (month, day, and year) Oct 22nd 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) B. C. R. R. Co

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Christopher Maddox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Bessie M. Maddox
(Address) 1841 Mc Henry St

15 JUL 27 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1923

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1923, to July 26, 1923.

that I last saw him alive on " " , 1923,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Abscess of lung

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? "

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Coolahan, M. D.

7/27 1923 (Address) 24 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fleurlis Lot	7/28 1923

20 UNDERTAKER J. B. Hepfield ADDRESS 2236 Fred'k Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

14 N. Fulton Ave

REVISED UNITED STATES STANDARD
CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonic* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tubercular.

Spec—12-23-21—E.B.R.S.—400 Eks.

D77835

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D77835

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1711 W. Lombard St. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Weigman

(a) Residence No. 1711 W. Lombard St. ..... St., ... Ward.....
(Usual place of abode) (If not a resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Famale	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 12, 1852

7-AGE.	If LESS than 1 day,
..71..yrs. ..mos. 13 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ..... None .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Denis Haeffner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Margaret

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

11- (Informant) Mr. P. Haeffner

(Address) 2126 W. Saratoga St.

15- JUL 27 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 25, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 10, 1923 to July 25, 1923

that I last saw her alive on July 25, 1923

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilitation of Heart

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. W. Cooksland M. D.

7/26, 1923 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cem	July 28 23

20-UNDERTAKER.	ADDRESS
Geo A. Farley	1800 W. Fayette

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77836

CERTIFICATE OF DEATH.

100-001 D77836

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1214 N. Parrish St. Ward) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hilda Tongue

(Residence in Baltimore: No. 1214 N. Parrish St. St.; yrs. 6 mos. 24 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced. (Write the word.): single

6-DATE OF BIRTH: January 31, 1923 (Month) (Day) (Year)

7-AGE: ..... yrs. 6 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: camp
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto. Md

PARENTS.

10-NAME OF FATHER: Walter Tongue

11-BIRTHPLACE OF FATHER, (State or Country): Md.

12-MAIDEN NAME OF MOTHER: Emma Gray

13-BIRTHPLACE OF MOTHER, (State or Country): Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Tongue

(Address) 1214 N. Parrish St.

15- Filed JUL 27 1923 ROBERT R. KRAUTS Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 26 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) ..... or contributed to ..... death.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Kennedy M. D. (Coroner)

July 27 1923 (Address) 1701 Eutaw Pl

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.
W. H. Carlin July 28 1923

20-UNDERTAKER, ADDRESS 1303
James H. Lewis Sons Co.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77837

CERTIFICATE OF DEATH.

47

D77837

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Evergreen Apartment ST., WARD)

2-FULL NAME Lillian E Constable

(a) RESIDENCE NO. Evergreen Places Palmer ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (~~HUSBAND of~~ or) WIFE of Charles B Constable.

6 DATE OF BIRTH (month, day, and year) May 6th. 1889

7 AGE — Years: 34 — Months: 3. — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home -

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER Charles B Gibson.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Tillman Island

12 MAIDEN NAME OF MOTHER Tenia Rechner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles B Constable (Address) Evergreen Apartment

15 JUL 27 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26th 1923

17 I HEREBY CERTIFY, That I attended deceased from Nov, 1921, to July 27, 1923

that I last saw her alive on July 27, 1923

and that death occurred, on the date stated above, at 5 30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breasts.
Metastases to Liver.

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Mar 1922

Was there an autopsy? No.

What test confirmed diagnosis? Exam. of Specimen

(Signed) Frowwood M.D., M. D.

7/27. 1923 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pork Wood cemetery — DATE OF BURIAL: July 28 1923

20 UNDERTAKER: Robt J Turner Inc. — ADDRESS 1442 Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Eichelberger ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77838

CERTIFICATE OF DEATH.

162 D77838

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., WARD)

2-FULL NAME Jennie Eichelberger

(a) RESIDENCE NO. 1909 E. 20th ST., WARD 10

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24, 1923

7 AGE: Years ... Months ... Days 2 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John F Eichelberger

11 BIRTHPLACE OF FATHER (city or town) Hooper's Is. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna C. Leinbach

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant John E Eichelberger (Address) 1909 E 20th St.

15 Filed JUL 27 1923 ROBERT R. KRAMER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1923

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1923, to July 26, 1923, that I last saw her alive on July 26, 1923, and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Congestive Atelectasis

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No .....

What test confirmed diagnosis? Phys. sign

(Signed) H M Freeman M. D.

19 (Address) 2631 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: July 27 1923

20 UNDERTAKER: Robt F Turner Inc ADDRESS 1442 Broadway

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D77839

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77839

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH 3242 Eastern Ave

Registered No.....

City of BALTIMORE: (No. Baltimore St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thos. W. Pulham

(a) Residence No. 3242 Eastern Av. St., No Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of ~~her~~ WIFE Jennie B. Pulham

6-DATE OF BIRTH (month, day and year) June 5, 1850

7-AGE. 73 yrs. 1 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Preacher
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer Retired

9-BIRTHPLACE (city or town) Ireland (State or Country), County Armagh

PARENTS.

10-NAME OF FATHER, Wm. Pulham

11-BIRTHPLACE OF FATHER (city or town) Ireland (State or Country), England

12-MAIDEN NAME OF MOTHER, Sarah Wright

13-BIRTHPLACE OF MOTHER (city or town) Ireland (State or Country) Armagh

14-(Informant) Chas. P. Athey

(Address) 2504 St. Paul St.

Filed JUL 27 1923 19 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 26/23

17- I HEREBY CERTIFY, That I attended deceased from July 1, 1923 to July 26, 1923 that I last saw h alive on July 26, 1923 and that death occurred, on the date stated above, at 7:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease of Heart (Mitral Insufficiency)

(Duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma, Chronic

(Duration) 9 yrs. mns. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry B. Athey, M. D

7/27/23 (Address) 2504 St. Paul St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Cathedral Cemetery	July 29, 1923
20-UNDERTAKER.	ADDRESS
Leibler & Snyder	1734 E. Eager St.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77840

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77840

CERTIFICATE OF DEATH.

78

1-PLACE OF DEATH

City of BALTIMORE: (No. 229 N Arlington Ave St., Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Lee

(Residence in Baltimore: No. 229 N Arlington St.; yrs., mos., ds.)

Married

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: M

4-COLOR OR RACE: C

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.)

6-DATE OF BIRTH: ~~Nov~~ June 1869
(Month) (Day) (Year)

7-AGE: 54 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Maryland

PARENTS:

10-NAME OF FATHER:

11-BIRTHPLACE OF FATHER, (State or Country):

12-MAIDEN NAME OF MOTHER:

13-BIRTHPLACE OF MOTHER, (State or Country):

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) House Keeper.

(Address)

15- Robert P. Harrison

Filed 192 Registrar.

Burial Permit Clerk.

JL 27 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 24 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Hypertrophy

(Duration) yrs. mos. ds.

(Signed) G. Hodes M. D.
(Coroner)

July 24 1923 (Address) 143 N Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: UNIVERSITY OF MARYLAND. DATE OF BURIAL, 192

20-UNDERTAKER: Commissioner Health. ADDRESS

JUL 27 1923

THE MORGUE.

0582

Per Wm. E. Woodall

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DECORATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Blks.

D77841

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77841

CERTIFICATE OF DEATH.

129

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1426 Pennsylvania Ave WARD) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Martin

(a) RESIDENCE No. 1426 Pennsylvania Ave WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Martin

6 DATE OF BIRTH (month, day, and year): 1859

7 AGE — Years: 64 — Months: - — Days: - — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Henry Hoch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Annie Rinfy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): William Martin 1426 Penna Ave

15 Filed JUL 27 1923 19

Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26 1923

17

I HEREBY CERTIFY, That I attended deceased from June 10, 1923, to July 26 1923.

That I last saw h e alive on June 26, 1923

and that death occurred, on the date stated above, at 4 30 a m.

The CAUSE OF DEATH* was as follows:

Chr Int Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Apoplexy (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas T Hamilton M. D.

July 27. 1923 (Address) 1504 McCulloh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: July 28 1923

20 UNDERTAKER: Martin Lake Co — ADDRESS: 821 W North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D77842

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D77842

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 342 E. 20th. ST., WARD)

2-FULL NAME George D. Bolton Jr.

(a) RESIDENCE NO. 342 E. 20th. ST., WARD .....

(Usual place of shode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. 21 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

E should be stated EXACTLY. PHYSICI... should be... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Feb. 5, 1922.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George D. Bolton

11 BIRTHPLACE OF FATHER (city or town) Harford Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Adelaide C. McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant George D. Bolton
(Address) 342 E. Twentieth St.

15 Robert P. Harrison
Registrar

JUL 27 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1923

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1923, to July 26, 1923 that I last saw him alive on July 25, 1923, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Entero-Colitis

(duration) ... yrs. ... mos 14 ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Wm Pearce M. D.

(Address) 5 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 7/28 1923

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

Spec—12-23-21—E.B R.S.—400 Bks.

D77843

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77843

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 707 S Milton Ave St., 1 Ward) 129 1st

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Jones

(a) Residence No. 707 S Milton Ave St., 1 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. — mos. — ds. How long in U. S., if of foreign birth? 64 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced ~~HUSBAND of (or)~~ WIFE of Frank Jones

6-DATE OF BIRTH (month, day and year) Feb 1st 1859

7-AGE. 64 yrs. 5 mos. 25 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer)..... at Home

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). City

PARENTS.

10-NAME OF FATHER, Henry Clay

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Katherine Clay

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mr Frank Jones

(Address) 707 S Milton Ave

15- Robert P. Harrison,
JUL 27 1923 192..... Registrar.
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 26 23

17- I HEREBY CERTIFY, That I attended deceased from June 30 1923 to July 26 1923 that I last saw h.. alive on July 26 1923 and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Heading of Cervix
Bright Kidney
Dec'd

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) 1 yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of.....

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) C. L. Cleveland, M. D.

7/27, 1923 (Address) 320 Gaurnier Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Carmel — DATE OF BURIAL, July 29 1923

20-UNDERTAKER, Peter Nicolaus 2000 — ADDRESS Eastern Av

Should be carefully supplied. ALL should be filled. Exact statement of OCCUPATION is very important. Cause of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Cause of DEATH instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77844

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77844

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Vernia Harold

(a) RESIDENCE NO. 154 No. Carey Stanley St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed, or Divorced, (write the word)~~: Married.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Christian J. Herold

6 DATE OF BIRTH (month, day, and year): June 30 1875

7 AGE: Years 48 yrs; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Edward Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): York Co Penn.

12 MAIDEN NAME OF MOTHER: Elizabeth Gamble

13 BIRTHPLACE OF MOTHER (city or town) (State or country): York Co Penna

14 Informant: Christian J Herold

(Address): 154 N. Stanley St.

15 Filed July 27 1923 Robert F. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26 1923

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1923, to July 26, 1923, that I last saw her alive on July 26, 1923, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Adeno-carcinoma of r. ovary. (cystic degeneration) (duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 6th

Was there an autopsy? No. (Microscopic exam)

What test confirmed diagnosis? Laboratory

(Signed) Dr E. Hayward M. D.

1923 (Address) Cathedral & Franklin Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: July 30 1923

20 UNDERTAKER: Jos. J. Herrmann

ADDRESS: 156 N. Luzerne

AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77845 HEALTH DEPARTMENT—CITY OF BALTIMORE D77845

CERTIFICATE OF DEATH. 45

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 158 N. Hane ST., WARD)

2-FULL NAME Frederick C. Stickelive

(a) RESIDENCE NO. 158 N. Hane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. 4 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Stickelive

6 DATE OF BIRTH (month, day, and year): March 3 1850

7 AGE: Years 73 Months 4 Days 17 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) Ger. (State or country)

12 MAIDEN NAME OF MOTHER Mary Holzherd

13 BIRTHPLACE OF MOTHER (city or town) Ger. (State or country)

14 Informant Aug. T. Emmo (Address) 158 N. Howe St.

15 Date JUL 27 1923, 19 Registrar

Robert F. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25, 1923,

17 I HEREBY CERTIFY, That I attended deceased from ~~June~~ Feb. 1, 1923, to July 25, 1923, that I last saw him alive on July 24, 1923, and that death occurred, on the date stated above, at 9.30a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Colon (Inoperable)

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb. 1923.

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Pessano, M. D.

July 25, 1923. (Address) Tem Hicks.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: July 28 1923

20 UNDERTAKER: Jos. J. Merra & Son — ADDRESS: 154 N. Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D77846

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77846

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Ogden

(a) Residence No. 1436 E. Fayette st. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1897

7-AGE.	If LESS than 1 day.
26 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. James Johnson

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Ella Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Hospital Records

(Address) M.T.H.

15- [illegible] Registrar.

Brid. Permit Clerk.

JUL 27 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 26, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 7 1923 to July 26 1923

that I last saw her alive on July 26 1923

and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum

(Signed) L. A. Labby M. D.

7-26-23 (Address) Municipal Tuc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Oak Lawn	7/28 1923

20-UNDERTAKER	ADDRESS
Liston P. Fussellbaugh	3620 St. Paul.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77847

CERTIFICATE OF DEATH.

44 D77847

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1044 N. Balto St. ST.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward X Kerner

(a) RESIDENCE. NO. 1044 N. Balto St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 9-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Structural Blocker

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Geo. X. Kerner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto - Md.

12 MAIDEN NAME OF MOTHER Sophia Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto - Md.

14 Informant Mrs Hafer
(Address) 1044 N Baltimore St

15 Filed ..., 19... Robert P. Harrison, Registrar

UL 27 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1923

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1923, to July 26, 1923, that I last saw h... alive on July 26, 1923, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Gastric (Pylric) Carcinoma

(duration) ... yrs. 5 mos. 17 ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Cofs. J. Murray, M. D.

July 27 1923 (Address) 510 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 28 1923
20 UNDERTAKER	ADDRESS
Stinson Fields	1201 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77848

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 100-001

D77848

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 537 N mount ST., 19 WARD)

2-FULL NAME Katherine Johnson

(a) RESIDENCE NO. 537 N Mount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 1-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .. min.
		7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Raleigh (State or country) NC

PARENTS

10 NAME OF FATHER Alphus Dixon

11 BIRTHPLACE OF FATHER (city or town) Charlotte (State or country) NC.

12 MAIDEN NAME OF MOTHER Daisy Johnson

13 BIRTHPLACE OF MOTHER (city or town) Raleigh (State or country) NC.

14 Informant Daisy Johnson (Address) 0-37 N mount st.

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

UL 28 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1923

17

I HEREBY CERTIFY, That I attended deceased from July 25, 1923, to July 27, 1923, that I last saw h alive on July 24, 1923 and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

7/27 1923 (Signed) B. S. French, M. D.

(Address) 1717 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 28 1923
20 UNDERTAKER	ADDRESS
Jam H. Carroll & Son	1655 Mosher

WRITE PLAINLY, with ordinary pen and ink. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of PLACE OF DEATH is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77849

CERTIFICATE OF DEATH.

90

D77849

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1768 E North Ave ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George W Blankenship

(a) RESIDENCE NO. 1768 E North Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Maud F. Blankenship

6 DATE OF BIRTH (month, day, and year) Aug 19 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Daniel W Blankenship

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Sophia Jenkins

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs Maud F. Blankenship

(Address) 1768 E North Ave

Register P. No. [illegible]

JUL 28 1923 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1922, to July 25, 1923

that I last saw h[illegible] alive on July 25, 1923

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

[illegible] Cirrhosis (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

What was there an autopsy?

What test confirmed diagnosis?

(Signed) J H Cushman M. D.

July 25 1923 (Address) 3100 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL July 28 1923

UNDERTAKER Geo C. Miller

ADDRESS 2334 Jeffers

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mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC
TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77850 ✓ D77850

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. St., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Pappington

(a) RESIDENCE NO. 3401 Greenway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 11 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 29 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER Dr. Thos Pappington

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Theresa Daley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): JOHNS HOPKINS HOSPITAL

15 Robert F. Harrison, Registrar

JUL 28 1923 . 19 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1923

17

I HEREBY CERTIFY, That I attended deceased from July 23, 1923, to July 25, 1923, that I last saw h[illegible] alive on July 25, 1923, and that death occurred, on the date stated above, at 5.55 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/25/23

Was there an autopsy? Yes No

What test confirmed diagnosis? Pathological Exam

(Signed) Warfield M Theobald M. D.

7/25, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem

DATE OF BURIAL: 7-28-1923

20 UNDERTAKER: Henry W. Jenkins & Son Co

ADDRESS: 324 N. Eutaw

mation should be carefully supplied. AGE should be
CAUSE OF DEATH in plain terms, so that it may be
TION is very important. See instructions on back of

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77851 D77851

CERTIFICATE OF DEATH.

144

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3907 Phila Av. ST.; No WARD) REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia M. Frasier

(Residence in Baltimore: No. 3907 Phila Av. St.; Lyrs. 3 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Married

6-DATE OF BIRTH, April 4, 1887 (Month) (Day) (Year)

7-AGE 36 yrs. 3 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Joseph Smith

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Catherine Kenny

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John T. Frasier

(Address) 3907 Phila Ave.

15-

Filed ....., 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 27, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 27 1923 to July 27 1923, that I saw h[illegible] alive on July 27 1923, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Shock due to Uterine Hemorrhage

(Duration) ....yrs. ....mo. ....da.

CONTRIBUTORY (Secondary) Obstetrical Shock

(Duration) ....yrs. ....mos. ....da.

(Signed) Louis Vogel M. D.

7/27, 1923 (Address) 2601 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Farmer or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery — DATE OF BURIAL July 30 23

20-UNDERTAKER Russ & Tuttle — ADDRESS 2332 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77852 D77852

CERTIFICATE OF DEATH.

44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2002 Orleans ST., WARD) 6

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Eckhardt

(a) RESIDENCE NO. 2002 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 6-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	57	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer) 869

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Louis Eckhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Michael

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mary Eckhardt (Address) 2002 Orleans

15 Roberts P. Harrison, Registrar

JUL 28 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1923

17 I HEREBY CERTIFY, that I attended deceased from Apr 10, 19 23 to July 25, 19 23.

that I last saw her alive on July 24, 19 23;

and that death occurred, on the date stated above, at 9 15 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C N Meyer M. D.

7/26 19 23 (Address) 26 38 E Brevs

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem

DATE OF BURIAL July 28 19 23

20 UNDERTAKER John Dellerich

ADDRESS 2008 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77853

CERTIFICATE OF DEATH.

D77853

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 906 Warner ST., ... WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Johnson

(a) RESIDENCE NO. 706 Warner ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifer yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) April 16-1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John N Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Viola Warner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) John N Johnson 906 Warner Ste

15 Filed ..... 19 ..... Registrar Robert F. Harrison, Burial Permit Clerk.

JL 28 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1923

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1923, to July 27, 1923 that I last saw her alive on July 16, 1923 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Pertussis (duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Convulsions (duration) yrs. mos. 1 hr.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edwin K. Ballard M. D.

7-28 1923 (Address) 1622 Mt Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	7/28 1923
20 UNDERTAKER	ADDRESS
Samuel Hendley	Balto

Spec.—1-10-21—M&T—1500 Bks. should be stated EXACTLY. PHYSICIAN should state AGE should be carefully supplied. Exact state or OCCUPATION CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77854

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77854

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Marlborough St. ST., (WARD) 14

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Rosenfeld

(a) RESIDENCE NO. Marlborough St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jonas Rosenfeld

6 DATE OF BIRTH (month, day, and year) Sept 17th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Solomon Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lena Edelenfeld

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr Cohen Mother of

(Address)

15 Robert P. Harrison, 19 Registrar

UL 28 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27th 1923

17 I HEREBY CERTIFY, That I attended deceased from May — 1923, to July 27 1923, that I last saw h[illegible] alive on July 27 1923, and that death occurred, on the date stated above, at 2 35 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma (ovary)
Peritoneal metastases
(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
Mitral Stenosis (duration) 21 yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings no microscopic confirmation

(Signed) Louis B. Hamburger M. D.

July 28, 1923 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chevra Shalom	July 29 1923
20 UNDERTAKER	ADDRESS
Dan Goldheim	718 W Mt Royal

AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D77855

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D77855

CERTIFICATE OF DEATH.

113

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 625 N Conway ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Jones

(Residence in Baltimore: No. 625 N Conway St.; yrs., 1 mos. 27 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May 31st, 1923 (Month) (Day) (Year)

7-AGE, yrs. 1 mos. 27 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), 625 N Conway Baltimore

PARENTS.

10-NAME OF FATHER, Manley H Jones

11-BIRTHPLACE OF FATHER (State or Country), E. St. Louis Ill.

12-MAIDEN NAME OF MOTHER Sarah Johnson

13-BIRTHPLACE OF MOTHER (State or Country) North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Manley Jones

(Address) 625 W. Conway St.

15-

Filed JUL 28 1923, 191

Robert P. Harrison
Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 27th, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 26th 1923, to July 27th 1923, that I saw her alive on July 26th 1923, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Status-epilepticus

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. mos. 1 ds.

(Signed) C. Goodtree M. D.

7/27/23 191... (Address) 3909 Gaswell Rd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincents

DATE OF BURIAL July 30th 1923

20-UNDERTAKER Leo G. Cook

ADDRESS North Howard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77856

CERTIFICATE OF DEATH.

113 D77856

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. 625 N Conway ST.; WARD N)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward F Jones

(Residence in Baltimore: No. 625 N Conway St.; ...yrs., ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, May (Month) 31st (Day), 1923 (Year)

7-AGE, ...yrs. 1 mos. 25 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), 625 N Conway St

PARENTS.

10-NAME OF FATHER, Manley F Jones

11-BIRTHPLACE OF FATHER (State or Country), E Md Jones Dec

12-MAIDEN NAME OF MOTHER Sarah Johnson

13-BIRTHPLACE OF MOTHER (State or Country), North Carolina

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Manley Jones

(Address) 625 W Conway St

15-

Filed ... Registrar.

JL 20 1923. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 25th (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 26th 1923, to July 27th 1923, that I saw him alive on July 27th 1923, and that death occurred, on the date stated above, at 12.20 A.M.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) ...yrs. ...mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ...yrs. ...mos. 1 ds.

(Signed) H C Boulton M. D.

7/28/23, MD... (Address) 3909 Gamon Blvd

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincents — DATE OF BURIAL, July 28th 1923

20-UNDERTAKER Leo G. Cook — ADDRESS North Harford

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77857

CERTIFICATE OF DEATH.

100-001 D77857

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 Barnes ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roth Frisby

(a) RESIDENCE NO. 1718 Barnes ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or Divorced. (~~write the word~~)
male	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) may 28 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	4	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore md
(State or country)

PARENTS

10 NAME OF FATHER George frisby

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore md

12 MAIDEN NAME OF MOTHER Annie anderson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore md

14 Informant Mary frisby
(Address) 1718 Barnes St

15 Filed [illegible] P. [illegible]
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-26-1923

17

I HEREBY CERTIFY, That I attended deceased from 7-22-[illegible], 1923, to 7-26-1923,

that I last saw him alive on 7-25-1923,

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

7-27-1923 (Address) 611-N-Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bury Cemetery — DATE OF BURIAL: July 29 1923

20 UNDERTAKER: Edward Bryan — ADDRESS: Orleans

JUL 28 1923

[illegible] Clerk.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary.

D77858

HEALTH DEPARTMENT—CITY OF BALTIMORE

168 D77858

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 312 So. Chester St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Chester Marciniak

(Residence in Baltimore: No. 312 So. Chester St.; 14 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Nov (Month) 3rd (Day) 1908 (Year)

7-AGE. 14 yrs. 8 mos. 24 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Md

PARENTS:

10-NAME OF FATHER. James J. Marciniak

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Louise Gisd

13-BIRTHPLACE OF MOTHER, (State or Country). Austria

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louise Marciniak

(Address) 312 So. Chester St

15- Filed 1923 Robert P. Harrison, 192 Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 27 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, and from Autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Strangulation — Suicide by hanging

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos A Boxton M. D.
Coroner.

July 27 1923 (Address) Curtis Bay

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Necropsy

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL. Holy Rosary Cem. DATE OF BURIAL. 7-30-1923

20-UNDERTAKER. Frederick W. Ozazewski ADDRESS. 1930 Eastern Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

L 28

Spec.—1-10-21—M&T—1500 Bks.

D77859

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77859

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 E. White Ave. ST., WARD) 17

2-FULL NAME William M. Frank

(a) RESIDENCE NO. 5 E. White Ave. ST., WARD

(Usual place of abode) (If out of resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helene D. Frank

6 DATE OF BIRTH (month, day, and year) Aug. 11th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt. Red Seal Oil Co.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John P. Frank

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Barbara Keck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria

14 Informant Mrs. Helene D. Frank

(Address) 5 E. White Ave. Hamilton

15 JUL 28 1923 19... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1923, to July 25, 1923

that I last saw him alive on July 25, 1923

and that death occurred, on the date stated above, at 10.15P m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Harry A Long M. D.

7/26 1923 (Address) Harford Rd. & Shaffer Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	July 28, 1923
20 UNDERTAKER	ADDRESS
Ralph B. Cook	1003 N. Bond St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. 77860 ✓ 77860

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77860 31 D77[illegible]

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 Hanover ST., WARD) W

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Celia Parker

(a) RESIDENCE NO 802 Hanover ST., W WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Peter J. Parker

6 DATE OF BIRTH (month, day, and year) [illegible] 3. 77

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
about	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Bailey Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Priscilla Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Edna Valentine

(Address) 1001 S. Sharp Street

15 JUL 29 1923 ROBERT R. KRAUTER, Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to July 26 1923

that I last saw him/alive on July 26, 1923

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Indefinite yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Bacteriological

(Signed) R. R. Crawford M. D.

July 27, 1923 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity — DATE OF BURIAL July 28 1923

20 UNDERTAKER William Cook — ADDRESS 502 E Pratt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. 78868 Charlotte V. Bingman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77861

CERTIFICATE OF DEATH. 159-002 D77861

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 773 N. Lexington ST., WARD)

2-FULL NAME Charlotte V. Bingman

(a) RESIDENCE No. 773 N. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16 23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
			12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Harry E Bingman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Norwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Harry E Bingman

(Address) W of Lexington

15 [illegible]

JUL 29 1923

ROBERT A. KOHLER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1923

17

I HEREBY CERTIFY, That I attended deceased from May 16, 1923, to July 28, 1923,

that I last saw her alive on July 27, 1923

and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. Hawkins M. D.

(Address) 1 W. 19 [illegible] Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Cem Frederick Co Md. DATE OF BURIAL July 28 1923

20 UNDERTAKER H. Maurice Rouston ADDRESS 230 N Green

AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATIONS on back of certificates.

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that TION is very important. See Instructions

164716

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77862

CERTIFICATE OF DEATH. X 58002 D77862

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

2-FULL NAME Isidor Arthur Monash

(a) RESIDENCE NO. 15 Colonial St. Charleston S.C.
(Usual place of abode) ST., WARD
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? — yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Mrs. A. Monash

6 DATE OF BIRTH (month, day, and year) Mar. 17 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S.C.

PARENTS

10 NAME OF FATHER Morris Monash

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Echaul

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky.

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL

15 JUL 29 1923 ROBERT R. KRAMER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1923

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1923, to July 28, 1923, that I last saw him alive on July 28, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acquired Hemolytic Jaundice
Cirrhosis Spleen Anemia

(duration) 1 yrs. mos de.

CONTRIBUTORY (Secondary) Splenectomy and Post Operative Shock (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of July 28'23

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Exam. Splenectomy

(Signed) A.T. Reichert, M. D.

, 19 (Address) John Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charleston S C

DATE OF BURIAL July 29 1923

20 UNDERTAKER Joseph Ahrens

ADDRESS 22 Bu

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77863

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

D77863

1 PLACE OF DEATH

REGISTERED No. C .....

CITY OF BALTIMORE (No. 132 East Fort Ave ST.: ... WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Charles Reed

(Residence in Baltimore: No. 132 East Fort Ave Stay ... yrs. ... mos. ... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 COLOR OR RACE: white | 5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: Oct (Month) 7 (Day), 1856 (Year)

7 AGE: 66 yrs. 9 mos. 21 ds. | If LESS than 1 day, ... hrs. or ... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9 BIRTHPLACE (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles Reed

11 BIRTHPLACE OF FATHER (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary Parks

13 BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lillie Kinsley

(Address) Curtis Bay

15 JUL 29 1923 ROBERT N. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 28 (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1923, to July 28 1923, that I saw him alive on July 27, 1923, and that death occurred, on the date stated above, at 5: 4 m.

The CAUSE OF DEATH* was as follows:

Myocarditis—
Chronic

(Duration) ... yrs. ... mos. ... ds

Contributory (SECONDARY) Cardiac Dilatation

(Duration) ... yrs. 1 mos. ... ds.

(Signed) E. T. Buxton M. D.

7/28, 1923 (Address) 301 East Cross

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. | In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19 PLACE OF BURIAL OR REMOVAL: Cedar Hill Cemetery | DATE OF BURIAL: July 30 1923

20 UNDERTAKER: J. Fen McCully | ADDRESS: 130 E. Fort Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77864

CERTIFICATE OF DEATH.

129 D77864

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST., WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John L. Seward

(a) RESIDENCE NO. 1807 Poplar Grove St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (~~write~~ the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary S Seward

6 DATE OF BIRTH (month, day, and year): april 16-1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): " "

12 MAIDEN NAME OF MOTHER: Mary S Pearson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): " Va

14 Informant: Mrs Treaty

(Address): 1807 Poplar Grove St.

15 Filed JUL 29 1923 ROBERT A. KRAUTH, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 27 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9- 1923 to July 27- 1923, that I last saw him alive on July 27 1923, and that death occurred, on the date stated above, at 5.55 Am hr.

The CAUSE OF DEATH* was as follows:

chronic nephritis.

myocarditis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Edward H. Radowske M. D.

7/27, 1923 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: 7/30 1923

20 UNDERTAKER: ROBERT BROOKS SON

ADDRESS COR CALHOUN HOLLINS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks. D77865

46307 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

✓ 177 D77865

OK accepted Geo. M. O.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST., WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma Jones

(a) RESIDENCE No. 919 Sterling ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) March 21-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER ~~Mitchell~~ James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Mildred Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 29 1923 ROBERT R. KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1923

17

I HEREBY CERTIFY, That I attended deceased from July 13, 1923, to July 27th, 1923, that I last saw her alive on July 27th, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Lys stricture of Oesophagus

(duration) yrs. 1/2 mos ds.

CONTRIBUTORY (Secondary) Pyopneumothorax

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 13/23

Was there an autopsy? Yes

What test confirmed diagnosis? Thoracentesis & X-ray

(Signed) Chas G. Heath, M. D.

, 19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Burnt Cremation DATE OF BURIAL July 30 1923

20 UNDERTAKER Edward Ryan ADDRESS 631 Orleans St

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77866

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77866

CERTIFICATE OF DEATH.

118-001

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Monument St. & Rutland Ave ST.; WARD)

2-FULL NAME Mrs. Rebecca Harum

(a) RESIDENCE. No. 2197 No. Fremont Ave ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred W yrs. mos. ds. How long in U. S., if of foreign birth? W yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Simon Harum

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Simon Harum

(Address) 2197 Fremont Ave

15 JUL 29 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1923

17 I HEREBY CERTIFY, That I attended deceased from 7/26, 1923, to 7/27, 1923, that I last saw h alive on 7/27, 1923, and that death occurred, on the date stated above, at 12.00 P.m.

The CAUSE OF DEATH* was as follows:

Cardiac failure with pulmonary edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Strangulated ventral hernia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7/26/23

Was there an autopsy? yes hernioplasty

What test confirmed diagnosis?

(Signed) A. Adler Sondheimer, M. D.

July 28 1923 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mehrem Herring Run — DATE OF BURIAL: July 29 1923

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77867

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77867

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 139 N Exeter St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leah Silberman

(Residence in Baltimore: No. 1396 Exeter St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): M

6-DATE OF BIRTH: Unknown (Month) (Day) 1 (Year)

7-AGE: 65 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Russia

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Morris Silberman

(Address) 139 N. Exeter St

JUL 29 1923 Filed 192.

ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: July (Month) 28 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, I find that said deceased came to Her death (Inquest, autopsy or Inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) 1 yrs. 6 mos. 2nd ds.

CONTRIBUTORY (Secondary) Broken Congestion

(Duration) yrs. mos. ds.

(Signed) Geo Ellis Koontz M. D.
(Coroner)

July 29 1923 (Address) 143 E Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Hebrew Henry Pk | DATE OF BURIAL: July 29, 1923

20-UNDERTAKER: Jack Levin | ADDRESS: 1439 E Balto St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. If UNKNOWN state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77868

CERTIFICATE OF DEATH.

90

D77868

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 39 St & Canterbury Rd ST., WARD)

2-FULL NAME Andrew J. Kelly

(a) RESIDENCE NO. 39 St. & Canterbury Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced, (write the word)~~
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary P Kelly

6 DATE OF BIRTH (month, day, and year) Nov 26, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Caleb Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S. A.

12 MAIDEN NAME OF MOTHER Catherine Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S. A.

14 Informant Andrew P. Kelly

(Address) 300 Union St. City

15 JUL 29 1923 ROBERT H. KRAUSE, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1923

17 I HEREBY CERTIFY, That I attended deceased from 7/19, 1923, to 7/28, 1923, that I last saw him alive on 7/27, 1923, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris (duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Louis H. Kolb, M. D.

July 29 1923 (Address) 601 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	July 30 1923

20 UNDERTAKER John O. Mitchell ADDRESS 120 W. Pagette St.

N. B. ~~Either~~ Each of these questions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77869

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D77869

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 E. Lake Ave ST., W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna Lloyd Black

(a) RESIDENCE No. 612 E. Lake Ave ST., W WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene Linton Black

6 DATE OF BIRTH (month, day, and year) July 30 1877

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
45	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Joel E. Lloyd

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.
(State or country)

12 MAIDEN NAME OF MOTHER Anna R. Erdman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md.
(State or country)

14 Informant Eugene Linton Black
(Address) 612 E. Lake ave

15 JUL 29 1923 ROBERT H. KRAUTER, Registrar. Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1921 to July 26 1923

that I last saw h[illegible] alive on July 26 1923

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 3+ yrs. mos ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Uremia

(Signed) Henry H. Erdman M.D.

(Address) Mayland

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Presbyterian Cemetery Govans DATE OF BURIAL July 29 1923

20 UNDERTAKER Chas. G. Black ADDRESS 742 N. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

5 Sr. Bal. Park Boulevard ✓

D77870

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

122-102 D77870

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2115 E Balt ST., | WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Adam Thirl

(a) RESIDENCE No. 2115 E Balt ST., | WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Sandra

6 DATE OF BIRTH (month, day, and year) Jan 24 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Express Transfer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Thirl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs G A Thirl

(Address)

15 JUL 29 1923 ROBERT R. KRAUTH, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1923

17

I HEREBY CERTIFY, That I attended deceased from June 12, 1923, to July 27, 1923, that I last saw h alive on July 27, 1923, and that death occurred, on the date stated above, at 8.55 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) W. A. Condon, M. D.

, 19 (Address) 5 E. Saratoga St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	July 30 1923
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Balt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy." "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non-alcoholic

Spec.—1-10-21—M&T—1500 Blks.

D77871

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 43 D77871

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elijah Johnson

(a) RESIDENCE NO. Fairfield Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 ~~Single~~, ~~Married~~, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not Known

6 DATE OF BIRTH (month, day, and year): 3 9 3

7 AGE: Years: 84 dys — Months: — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mary Johnson (Address): Fairfield Md

15 Filed: JUL 28 1923 ROBERT R. KRAMER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 1923

17 I HEREBY CERTIFY, That I attended deceased from July 2 1923 to July 28 1923, that I last saw him alive on July 28 1923, and that death occurred, on the date stated above, at 1 05 AM m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cheek. (Cachexia)

(duration) 2 yrs. - mos - ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of July 27, 1923

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Edward A. Kalowski, M. D.

. 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: July 30 1923

20 UNDERTAKER: Freeman Cook — ADDRESS: 502 E North Ave

N. B.—WRITE LEGIBLY. All questions must be answered. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77872

CERTIFICATE OF DEATH.

31 D77872

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 Abbottston ST., 0 WARD)

2-FULL NAME Helen F. Baum

(a) RESIDENCE NO. 1530 Abbottston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H.

6 DATE OF BIRTH (month, day, and year) Dec. 8 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER John F. Wright

11 BIRTHPLACE OF FATHER (city or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Eleanor Gardner

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant John F. Wright

(Address) 1530 Abbottston St.

15 JUL 29 1923 ROBERT R. KRAUTH, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1923

17 I HEREBY CERTIFY, That I attended deceased from June 6 1923, to July 26 1923,

that I last saw h[illegible] alive on July 25 1923,

and that death occurred, on the date stated above, at 5.30 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum & Exam

(Signed) Richard L Cochran M. D.

19 (Address) 1042 Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Eastern Md July

DATE OF BURIAL 30 1923

20 UNDERTAKER Wm Cook

ADDRESS Eastern

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77873

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 D77873

REGISTERED NO. D77873

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1520 N. Bond St.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Mary (Mrs. David) Trott

(Residence in Baltimore: No. 1520 N. Bond St.; 80 yrs. mos. 26 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 SINGLE, MARRIED, WIDOWER, OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: July (Month) 2 (Day), 1843 (Year)

7 AGE: 80 yrs. mos. 26 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Dist. Md.

PARENTS

10 NAME OF FATHER: George Burkert

11 BIRTHPLACE OF FATHER (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank B. Trott

(Address) 432 N. Hilton st

15 JUL 29 1923 ROBERT R. KRAUTER, Burial Permit Clerk REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 28 (Day), 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1923, to July 28, 1923, that I saw her alive on July 27, 1923, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Cystic Carcinoma

(Disease) (Duration) yrs. 2 mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) E. A. Schultz M. D.

July 28, 1923 (Address) 1107 N. Caroline St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: July 31st 1923

20 UNDERTAKER: George Schulting & Sons — ADDRESS: 1126 E. Monument

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77874

CERTIFICATE OF DEATH.

7/4 801 D77874

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1430 E Fort Ave (Street) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Flynn

(a) RESIDENCE NO. 1430 E. Fort Ave (Street) WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Patrick Flynn

6 DATE OF BIRTH (month, day, and year): Nov. 6, 1873

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or min.
50	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Wm Mulligan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Mulligan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Patrick F Flynn

(Address): 1430 E Fort Ave

15 JUL 30 1923 ROBERT N. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-26 1923

17 I HEREBY CERTIFY, That I attended deceased from 7-23, 1923, to 7-26, 1923.

that I last saw her alive on 7-25-23, 19....,

and that death occurred, on the date stated above, at 7 20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Elijah J Russell M. D.

19 (Address) 156 N Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	July 29, 23
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Light St.

N. B.—WRITE PLAINLY, with indelible pencil. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D77875

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77875

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., Ward)

(If death occurred in a hospital or institution, give Its NAME instead of street and number.)

2-FULL NAME Anna Thomas

(a) Residence No. 1708 Carter st. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1910

7-AGE.	If LESS than 1 day,
13 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work School-girl

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town).....
(State or Country), Maryland

PARENTS

10-NAME OF FATHER, John Thomas

11-BIRTHPLACE OF FATHER (city or town).....
(State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Anna ?

13-BIRTHPLACE OF MOTHER (city or town).....
(State or Country). Maryland

14-
(Informant) Hospital Records
(Address) M. T. H.

15-
JUL 30 1923
ROBERT R. KRAMER
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 28, '23.

17- I HEREBY CERTIFY, That I attended deceased from July 10, 1923 to July 28 1923

that I last saw h[illegible] alive on July 28 1923

and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Bin Medium X-ray

(Signed) L. A. Lalley M. D.

7-28, 1923 Address Municipal Tbc. Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Laurel Cem	7-31-1923
20-UNDERTAKER.	ADDRESS
Daniel Easton	Baltimore

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S DIAGNOSIS must be clearly specified. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77876

D77876

141

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST., 9, WARD)

2-FULL NAME Violet M. Bazile

(a) RESIDENCE NO. 930 Eutaw St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Unknown. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Bazile. (Husb)

6 DATE OF BIRTH (month, day, and year): June 28, 1902

7 AGE: Years 21 Months Days 28. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Alex. Gibson.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Kasie Ebb.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): JOHNS HOPKINS HOSPITAL Records

15 Filed JUL 31 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 26 1923

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1923, to July 26, 1923, that I last saw her alive on July 26, 1923, and that death occurred, on the date stated above, at 10 32 A. m.

The CAUSE OF DEATH* was as follows:

Retroposition of uterus (duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary) Acute respiratory failure during Operation (duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 26-1923

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Eugene E Goldbeck M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 7-30 1923

20 UNDERTAKER: David Easters — ADDRESS: 916 Pa Ave

NOTE—INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Pks.

D77877 HEALTH DEPARTMENT—CITY OF BALTIMORE D77877

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., ... Ward) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Oscar Gittings

(a) Residence No. 822 Greenmount Ave Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1919.

7-AGE, 4 yrs. mos. ds. If LESS than 1 day, hrs. or. min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None.

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Wm. Gittings

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Martin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md,

14- (Informant) Hospital Records

(Address).....

15- Filed ..... 192.. ROBERT P. KRAUTZ, Registrar.

JUL 30 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7-22-23

17- I HEREBY CERTIFY, That I attended deceased from 7/22/23, 19.. to 7/27/23 19..
that I last saw h.. alive on 7/27/23 19..
and that death occurred, on the date stated above, at 3.45 a.m.
The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia.

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Failure 12 hr

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) K. L. Kolb, M. D.

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Laurel-Lawn	7-30, 1923
20-UNDERTAKER,	ADDRESS
Daniel Easton	Penna

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77878

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77878

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital ST., WARD)

2-FULL NAME William Chester

(a) RESIDENCE NO. 1213 Division St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Unknown

14 Informant Municipal Hospital Records. (Address)

15 JUL 28 1923 19 ROBERT R. KRAMER. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27, 19 23

17

I HEREBY CERTIFY, That I attended deceased from October 30. 19 22. to July 27. 19 23.

that I last saw him alive on July 26. 19 23.

and that death occurred, on the date stated above, at 9:50 A.M.

The CAUSE OF DEATH* was as follows:

Senility

Arteriosclerosis & Hypostasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (Terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude S. Dean, M. D.

7-27-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	7-31 19 23
20 UNDERTAKER Daniel Carter	ADDRESS 716 Pa Ave

N. B.—WRITE LEGIBLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77879

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 D77879

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 609 W. Franklin ST., ... WARD)

2-FULL NAME Henrietta C. Richmond

(a) RESIDENCE NO. 609 W. Franklin ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

17

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calif former

PARENTS

10 NAME OF FATHER John B. Richmond

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Sarah J. Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.J.

14 Informant Ellen M. Gray
(Address) 609 W. Franklin St

15 JUL 30 1923 ROBERT R. KRAMER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1923

17 I HEREBY CERTIFY, That I attended deceased from July 24 1923 to July 28 1923.

That I last saw her alive on July 28 1923,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Acute Articular Rheumatism

(duration) — yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) M Baumgartner M. D.

7/29 1923 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount July. 31 1923

DATE OF BURIAL

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E. Pratt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77880

CERTIFICATE OF DEATH.

74-091 D77880

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2216 N. Calvert ST., ... WARD) 17

2-FULL NAME William Henry Moffett

(a) RESIDENCE NO. 2216 N. Calvert ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. 11 mos. 25 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella B. P. Moffett

6 DATE OF BIRTH (month, day, and year) Aug. 2, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retail Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Henry Moffett

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Catherine Leonard

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Pennsylvania

14 Informant W. Edwin Moffett
(Address) 2216 N. Calvert Street

15 JUL 30 1923 ROBERT A. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Jany 1, 1923, to July 27, 1923, that I last saw h alive on July 27, 1923, and that death occurred, on the date stated above, at 11-40 Pm.

The CAUSE OF DEATH* was as follows:

Senile Arterio Sclerosis (duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) ... yrs. -- mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W A Fair M. D.

7/28 1923 (Address) 12 E 25th St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 7/30 1923

20 UNDERTAKER Henry W. Mears & Son 805

ADDRESS N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77881

D77881

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 7/1 901

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond H. Williams

(a) RESIDENCE NO. 1342 6th Ave., WARD Huntington, W. Va.

(Usual place of abode) (If not a resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 11, 1916

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	7	0	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-boy

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Raymond H. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Edna M. Heinekamp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records.

(Address)

15 Filed JUL 30 1923 ROBERT R. KRAMER, Registrar Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29, 1923.

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1923. to July 29, 1923. that I last saw him alive on July 29, 1923. and that death occurred, on the date stated above, at 12:30 P m.

The CAUSE OF DEATH* was as follows:

Acute Pneumococcic meningitis.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Spinal Fluid Study

(Signed) B. M. Rhodes, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: 7/30 1923

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

N. B.—All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77882

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77882

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2309 Hanford ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Marion McDonald.

(a) RESIDENCE NO. 2309 Hanford ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James P. McDonald

6 DATE OF BIRTH (month, day, and year) Nov. 8-1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City Md.

PARENTS

10 NAME OF FATHER Frederick Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Bridget McCartney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant James P. McDonald

(Address) 2309 Hanford ave

15 DATE RECEIVED JUL 30 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 25 1923

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1923, to July 25, 1923, that I last saw her alive on July 21, 1923, and that death occurred, on the date stated above, at 5.30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Robert L. Caldwell, M. D.

July 28 1923 (Address) 2117 Maryland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem DATE OF BURIAL 7/31 1923

20 UNDERTAKER George J Ruth ADDRESS 1735 Hanford ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

165134 D77883

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77883

CERTIFICATE OF DEATH.

16-002

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST., 9 WARD)

2-FULL NAME Ida Warnecker.

(a) RESIDENCE NO. 842 S. Kenwood Ave ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 mo 1 yrs. ... ds. · How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 6, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ... (State or country) Md.

PARENTS

10 NAME OF FATHER George Warnecker.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Venker.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL Records

(Address)

15 Filed JUL 30 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1923

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1923. to July 27, 1923.

that I last saw her alive on July 27, 1923

and that death occurred, on the date stated above, at 4.25 A. m.

The CAUSE OF DEATH* was as follows:

DYSENTERY (FLEXNER TYPE

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) FURUNCULOSIS

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Curlapin

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: First Evangelical Cemetery — DATE OF BURIAL: July 30 1923

20 UNDERTAKER: H. Sanders Sons — ADDRESS: 1110 Fleet St.

N. B. WRITE LEGIBLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D77884 HEALTH DEPARTMENT—CITY OF BALTIMORE

D77884

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Hyde

(a) Residence No. 1024 Lendenhall st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Not known

6-DATE OF BIRTH (month, day and year): 1886

7-AGE: 37 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town): Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Jacob Green

11-BIRTHPLACE OF FATHER (city or town): Baltimore (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Julia St. John

13-BIRTHPLACE OF MOTHER (city or town): (State or Country), Virginia

14-

(Informant): Hospital Records

(Address): M.T.H.

15-FILED JUL 30 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 27, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 25, 1923 to July 27 1923

that I last saw her alive on July 27 1923

and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 6 ? mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray

(Signed) L. A. Lally M. D

7-27-23 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: July 30 1923

20-UNDERTAKER: Sitz Brown & Son — ADDRESS: 108 W. Monto St

should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L D77885

CERTIFICATE OF DEATH.

112 D77885

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 Perry Street ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Harris

(a) RESIDENCE. NO. 106 Perry Street ST., W WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Harris

6 DATE OF BIRTH (month, day, and year) July 7 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Ellen Harris (Address) 106 Perry St

15 Filed JUL 30 1923 ROBERT R. KRAMER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1923

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1923, to July 27, 1923, that I last saw h. alive on July 27, 1923, and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Gastritis acute

Duration from Eating

(duration) 1 yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Dis Anemia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. H. Flowers, M. D.

July 28 1923 (Address) 712 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn St	July 30 1923
20 UNDERTAKER	ADDRESS
S. H. Brown & Son	1618 Mont

THIS is very important. See instructions on back of

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77886

CERTIFICATE OF DEATH.

X 31

D77886

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3504 Roland Ave (St.) (WARD) 13

2-FULL NAME Mary J. Grady

(a) RESIDENCE NO. 3504 Roland Ave W

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of: James P. Grady

6 DATE OF BIRTH (month, day, and year): Oct 10 1849

7 AGE: Years 73 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Eli Leizear

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): John D. Fraser 3504 Rolandave

15 JUL 30 1923 ROBERT R. KRAUTH Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 28 1923

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1923, to July 28, 1923, that I last saw her alive on July 28, 1923, and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Virginia

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? microscopic

(Signed) J. Rowan M. D.

July 30/23 (Address) 660 W 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Savage Md — DATE OF BURIAL: July 31 1923

20 UNDERTAKER: Cahenower & Son — ADDRESS: Chestnut Ave

N. B. WRITE PLAINLY with pen and ink. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77887

CERTIFICATE OF DEATH.

185 D77887

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Women's Hospital ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Mattie B. Milliken

(Residence in Baltimore: No. 3 Chauncey Square, Guilford St.; yrs., 5 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, March 11 (Month) (Day), 1872 (Year)

7-AGE, 51 yrs. 4 mos. 18 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country) Wheeling W. Va.

PARENTS.

10-NAME OF FATHER, James O. Bates

11-BIRTHPLACE OF FATHER (State or Country), Steubenville O

12-MAIDEN NAME OF MOTHER Julia A. Smith

13-BIRTHPLACE OF MOTHER (State or Country), Lectown, W. Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard Milliken

(Address) 3 Chauncey Square Guilford

15- JUL 30 1923 01 ROBERT R. KRAMER, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 28 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fall
Mental Aberation

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Sudden Hemorrhage

(Duration) yrs. mos. ds.

(Signed) Geo Clinton Ridle M. D.

July 28 1923 (Coroner) (Address) 1430 Bond

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Loudon Park Cem. DATE OF BURIAL, 7-30, 1923

20-UNDERTAKER Henry W. Jenkins Sons Inc ADDRESS Orchard & Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77888

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77888

45

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hosp. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearce & Thompson

(a) RESIDENCE NO. 141 W Belvedere ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie V. Manger

6 DATE OF BIRTH (month, day, and year) Nov 15-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	44	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanical Dentist.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Thos Thompson

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Georgia Pearce

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Lillie V. Thompson
(Address) 141 W. Belvedere St

15 Filed JUL 30 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 26 1923

17 I HEREBY CERTIFY, That I attended deceased from May, 1923, to June 25, 1923.

that I last saw him alive on June 25, 1923

and that death occurred, on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of Rectum

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Rectal exam.

(Signed) E A Hutchins, M. D.

, 19 (Address) 1010 N Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: July 30 1923

20 UNDERTAKER: John Ellis

ADDRESS: 2008 Eutaw

Spec.—8-24-14—M. & T.—2000 Bks.

Kreczmer. ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77889

D77889

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Milton Ave, Lakeland, ST., 25 WARD) REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME LeRoy George Kreczmer

(Residence in Baltimore: No. Same St.; ....yrs.,....mos.....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.) Single

6-DATE OF BIRTH, Oct 25, 1922 (Month) (Day) (Year)

7-AGE, ...yrs. 9 mos. 3 da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. John C. Kreczmer.

11-BIRTHPLACE OF FATHER (State or Country). Atlanta Ga.

12-MAIDEN NAME OF MOTHER Agnes Maka

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Lawrence Wheeler MD

(Address) Lakeland, Baltimore Co. Md.

15- JUL 30 1923 ROBERT R. KRAUTER, Registrar.
Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 28, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 2 1923, to July 28 1923, that I saw h[illegible] alive on July 27 1923, and that death occurred, on the date stated above, at 4:10 P. m.

The CAUSE OF DEATH* was as follows:

Thrombosis

(Duration) ....yrs. 2 mos. 26 da.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....da.

(Signed) H. Lawrence Wheeler M. D.

July 28, 1923 (Address) Lakeland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. St. Stanislaus

DATE OF BURIAL. July 30, 1923

20-UNDERTAKER William Fierson & Son

ADDRESS 1[illegible] Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Schwenk.

D77890

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

167-001

Registered No. D77890

1-PLACE OF DEATH

City of BALTIMORE: (No. 222 S. Bruce St., Ward)

2-FULL NAME. Rosa. Schwenk

(Residence in Baltimore: No. 222 S. Bruce St.; yrs. 40 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. Nov. (Month) 10 (Day) 1859 (Year)

7-AGE. 63 yrs. 8 mos. 19 ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Housework
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Schwenk

(Address) 222 S. Bruce St.

15. JUL 30 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July. (Month) 28 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Poisoning

Suicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo Edmon Rhoads M. D.

July 28 1923 (Coroner) (Address) 1445 N. Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Western Cem. DATE OF BURIAL. July 30. 1923

20-UNDERTAKER. E. W. Dill ADDRESS. 3199 Fredk. Ave.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Approximate ages may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

KODAK S·A·F

Motschiedler

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7H-001 D77891

D77891

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2244 E North ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Detrich Motschiedler

(a) RESIDENCE NO. 2244 E North ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Motschiedler

6 DATE OF BIRTH (month, day, and year) Nov 6-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	66	8	22.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Motschiedler

(Address) 2244 E North ave

15 JUL 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1923

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1923, to July 27, 1923, that I last saw h— alive on July 27, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy. Right Hemiplegia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. B. Fuge, M. D.

(Address) 630 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1st United German Evan Cem	July 30, 23
20 UNDERTAKER	ADDRESS
Asso C Smiller	2334 Huffman

I. B. Write plainly and with pencil. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77892

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 D77892

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 123 Scott ST., WARD)

2-FULL NAME Roland Leo Feathers

(a) RESIDENCE NO. 123 Scott ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	1	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm E. Feathers

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Lillian Scott

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md

14 Informant Wm E. Feathers
(Address) 123 Scott St

15 Filed JUL 30 1923 ROBERT A. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1923

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1923, to July 29 23, 19....,
that I last saw h... alive on July 29 23, 19....,
and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) ..... M. D.

July 29, 1923 (Address) 910 W. ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 30 1923
20 UNDERTAKER	ADDRESS
Wm J. Rickert & Sons	North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec–12-23-21–E.B.R.S.–400 Bks.

D77893

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77893

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Winfield

(a) Residence No. 1618 Carlos Terrace Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1903

7-AGE. 20 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) Unknown (State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown (State or Country),

14- (Informant)..... Hospital Records

(Address)..... M. T. H.

15- Filed JUL 30 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 29, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 6 1923 to July 29 1923 that I last saw h.. alive on July 27 1923 and that death occurred, on the date stated above, at 7.40 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary TB.

(Duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Xray - Sputum

(Signed) L. A. Lilly, M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Druid Ridge	7.31, 1923
20-UNDERTAKER, George T. C. Libra	ADDRESS 513 Lanvale St

27

should be carefully supplied. AGE should be stated EXACTLY. If infant, state hours, days or months. Occupation should be properly classified. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

2529 Eastern ave

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77894

CERTIFICATE OF DEATH.

56

D77894

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 325 S. Duncan ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. Aupperley

(a) RESIDENCE NO. 325 S. Duncan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 7 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Walter Aupperley

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Josephine Blachowicz

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Walter Aupperley
(Address) 325 S Duncan St.

15 JUL 30 1923 19 ROBERT A. [illegible]
Special Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1923

17 I HEREBY CERTIFY, That I attended deceased from July 29 1923 to July 29 1923

that I last saw him alive on July 29 1923

and that death occurred, on the date stated above, at 8.15 p m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Andrew Kwiatkowski, M. D.

19 (Address) 2579 Eastern Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 31 1923

20 UNDERTAKER ADDRESS

John M Weber 1803 Bank

N. B.—WRITE PLAINLY. Words should be spelled out. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Blks. George Witkowski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77895

CERTIFICATE OF DEATH.

100-901 D77895

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2013 Fleet. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Witkowski

(a) RESIDENCE No. 2013 Fleet St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male.	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
			6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Lawrence Witkowski

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Ethel Dymka

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Lawrence Witkowski.
(Address) 2013 Fleet St

15 Filed JUL 30 1923 ROBERT A. KRANTZ Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1923

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1923, to July 29, 1923.

That I last saw h alive on July 29, 1923,

and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Kirton J. Dandor, M. D.

, 19 (Address) 2035 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 30 1923

20 UNDERTAKER	ADDRESS
John M. Weber	1803 Bank

N. B.—WRITE PLAINLY, with unfading ink. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77896

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D77896

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Vincent ST., WARD)

2-FULL NAME James Edward Dorsey

(a) RESIDENCE NO. 1622 Vincent ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Dorsey

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51 +	+		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Lizzie Dorsey (Address) 1622 Vincent

15 Filed JUL 30 1923 ROBERT R. KRAUTER Registrar Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1923

17 I HEREBY CERTIFY, That I attended deceased from May 22 1923 to July 27 1923 that I last saw him alive on July 25 1923 and that death occurred, on the date stated above, at 3.35 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) + yrs. 2 mos 17 ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis

(duration) + yrs. 2 mos. 17 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Charles E. Clark M. D.

July 26 1923 (Address) 1306 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Auburn	7/30 1923
20 UNDERTAKER Harry H. Dunn	ADDRESS 303 Freeman

GE should be stated EXACTLY. PHYSICIANS should
mation should be carefully supplied. AGE s
CAUSE OF DEATH in plain terms, so that it n
TION is very important. See instructions on b

Spec. 1-10-21 M&T 1500 Bks.

D77897

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 D77897

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2434 Maryland Ave. (WARD) Tidball

2-FULL NAME Miss Elizabeth

(a) RESIDENCE No. 2434 Maryland ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): Oct 8 1840

7 AGE: Years 82 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Winchester Va

PARENTS

10 NAME OF FATHER: Alexander Va

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: E. McGuire

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Winchester Va

14 Informant: Lucy B Jones

(Address) Winchester Va

15 JUL 30 1923 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29th 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 29th 1923. to July 24th 1923.

that I last saw her alive on July 23rd 1923.

and that death occurred, on the date stated above, at 8:00 A. m.

The CAUSE OF DEATH* was as follows: Sudden failure of heart following exertion. No definite organic lesions had been perceptible. General weakness, emaciation & "Senility" seems were contributory. Patient during the weeks I attended her

(Duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? X Nursing

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? Urinalyses. Physical signs & blood pressure.

(Signed) C. H. Thompson M. D.

7/29 1923 (Address) 3402 Walbrook Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Winchester Va — DATE OF BURIAL: 7/30 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 502 E Hoffman

N. B.—WHITE PAPER. TYPE. INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77898

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9 D77898

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3338 Old York rd ST., WARD)

2-FULL NAME albert Davis

(a) RESIDENCE NO. 3338 Old York rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) ~~WIFE~~ of —

6 DATE OF BIRTH (month, day, and year) Jan. 7, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) md

PARENTS

10 NAME OF FATHER Albert Davis

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) md

12 MAIDEN NAME OF MOTHER Agnes Roark

13 BIRTHPLACE OF MOTHER (city or town) West Va (State or country)

14 Informant Albert Davis (Address) 3338 Old York Road

15 Filed JUL 30 1923 ROBERT T. KRAMER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1923

17

I HEREBY CERTIFY, That I attended deceased from July 17, 1923, to July 29, 1923, that I last saw him alive on July 29, 1923 and that death occurred, on the date stated above, at 2.30 p m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) — yrs. — mos 21 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) — yrs. — mos. 12 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John L. Fenby, M. D.

(Address) 3520 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
mt Olivet	July 30 1923

20 UNDERTAKER Wm. Leavy & Son ADDRESS E. Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77899

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77899

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 N. Eden ST., WARD) 10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Lee

(a) RESIDENCE NO. 718 N. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Lee

6 DATE OF BIRTH (month, day, and year) Sept 6 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
43	—	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Foreman

(c) Name of employer Clarkson

9 BIRTHPLACE (city or town) (State or country) St Marys Co: Md

PARENTS

10 NAME OF FATHER Jim Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Teresa Goss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Martha Lee (Address) 718 Eden Street

15 JUL 30 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 27 1923

17

I HEREBY CERTIFY, That I attended deceased from June 14 1923, to July 27 1923, that I last saw him alive on July 27, 1923, and that death occurred, on the date stated above, at 12.05 P m.

The CAUSE OF DEATH* was as follows:

(a) Tuberculosis of lungs

(duration) — yrs. 7 mos — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W H Carzill, M. D.

7-29-1923 (Address) 611 N Carolina

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys County Md	July 31 1923
20 UNDERTAKER	ADDRESS
Mrs R C Elliott	Leonardtown Md

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D77900

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D77900

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Tuberculosis Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Collins

(a) Residence No. 1102 Burgundy st. St., W Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Marri ed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Not stated

6-DATE OF BIRTH (month, day and year) 1868

7-AGE.	If LESS than 1 day.
55 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS

10-NAME OF FATHER. Mike Collins

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Mary Kennedy

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed JUL 30 1923 ROBERT R. KRAMES Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 28, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 16, 1923 to July 28, 1923.

That I last saw him alive on July 28, 1923

and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. A. Lally M. D.

7-28-23. (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross Cemetery DATE OF BURIAL. 7.30. 1923

20-UNDERTAKER. E. B. Hoke ADDRESS 104 E West St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77901

Burner.

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 60-001 D77901

CERTIFICATE OF DEATH.

REGISTERED NO. 2304

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No.) Monument & Rutland Aves. (Ward) 2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Hebna Burner (Burner)

(a) RESIDENCE. No. 617 So. Wolfe St., Ward. Carlisle W Va

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced: HUSBAND of ~~or WIFE of~~ John Burner

6 DATE OF BIRTH (month, day, and year): Apr. 4-1894

7 AGE: Years 29 | Months 3 | Days 25 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): " "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Austria

PARENTS

10 NAME OF FATHER: Martin Maslonka

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: John Burner

(Address) Carlisle, W. Va

15 Filed JUL 30 1923 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 1923

17

I HEREBY CERTIFY, That I attended deceased from July 11, 1923, to July 29, 1923.

that I last saw her alive on July 29, 1923.

and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac failure.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Exophthalmic goitre.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 15, 1923

Thyroidectomy.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

7/29, 1923 (Address) Hebrew Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Carlisle, W. Va

DATE OF BURIAL: 7/30 1923

20 UNDERTAKER: William Fiedler

ADDRESS [illegible]

INFORMATION TO BE CAREFULLY SUPPLIED. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77902

HEALTH DEPARTMENT—CITY OF BALTIMORE

88

D77902

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Union Memorial Hospital.

CITY OF BALTIMORE: (No. 1514 Druid Park Dr. ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Jacob Goldstein

(a) RESIDENCE NO. 1518 E. Fayette St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Benjamin Goldstein (S)

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Rosie Kohen (S)

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Rose Lucas

(Address)

15 Filed ..... 19..... ROBERT A. KRAMER

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1923

17 I HEREBY CERTIFY, That I attended deceased from June 29 .1923. to July 29 .1923.

that I last saw him alive on July 29 .1923.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Endocarditis & Aortic Insufficiency and Stenosis and Mitral insufficiency.

(duration) 0 yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

cystitis duration — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical course.

(Signed) Jno. McManus, M. D.

1923 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rebecca Mt Sinai DATE OF BURIAL July 30 1923

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto

N. B.—WRITE PLAINLY, WITH INK. All items must be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

27903

REGISTERED NO. 7903

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2119 Herbert St (WARD)

2-FULL NAME Elsworth H. Fleetwood

(Residence in Baltimore: ~~No.~~ 2119 Herbert St; yrs. 5 mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: White

5-SINGLE MARRIED WIDOWED OR DIVORCED (Write the word): Chld.

6-DATE OF BIRTH: (Month) Mar (Day) 11, 1923 (Year)

7-AGE: yrs. 4 mos. 18 ds. If LESS than 1 day, hrs., or min.?

8-OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Balto

PARENTS

10-NAME OF FATHER: William Fleetwood

11-BIRTHPLACE OF FATHER (State or country): Md

12-MAIDEN NAME OF MOTHER: Mary E. Kalbaugh

13-BIRTHPLACE OF MOTHER (State or country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Wm. Fleetwood

(Address): 2119 Herbert St

JUL 30 1923

ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: July (Month) 29 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 7-21, 1923, to, 7-29, 1923, that I saw h— alive on 7-28-1923, and that death occurred, on the date stated above, at 11.50 a.m.

The CAUSE OF DEATH* was as follows:

Whooping Cough.

(Duration) yrs. mos. 2 wks. ds.

Contributory (SECONDARY) Marasmus

(Duration) yrs. mos. ds.

(Signed) William Fleetwood M.D.

7/29 1923. [Address] 1920 N. Calhoun

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE [FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS]

At place of death yrs mos ds. In the State yrs mos ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Wards Chapel

DATE OF BURIAL: July 31, 1923

20-UNDERTAKER: John J. Fields

ADDRESS: 1200 N. Turnbull

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D77904

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

D77904

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 E. Chase ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles R. Crose

(a) RESIDENCE NO. 1510 E. Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. 0 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Catherine Crose

6 DATE OF BIRTH (month, day, and year) July 24 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER George Crose

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Ida L. Fuller

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mrs. W. L. Rust (Address) 1510 E. Chase St

15 JUL 30 1923 ROBERT N. KRAMER Registrar Bureau of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1923

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1923, to July 28, 1923,

that I last saw him alive on July 26, 1923,

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Pleurisy Tuberculosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Gilbert H. Levy M. D.

7-30, 1923 (Address) 1305 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery | DATE OF BURIAL: July 31

20 UNDERTAKER: Henry Hoeck Son | ADDRESS: 1301 Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state
mation should be carefully supplied. AGE should be stated EXACTLY.
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D77905 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77905

49

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1113 Greenmount Ave ST., 10 WARD)

2-FULL NAME William J. Healy

(a) RESIDENCE NO. 1113 Greenmount Avenue ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mollie Herbert

6 DATE OF BIRTH (month, day, and year) ----------

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
49	--	----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Healy

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Anne McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ireland

14 Informant Miss Lizzie Healy
(Address) 1117 N. Caroline St.

15 JUL 30 1923 ROBERT N. KRAUTER, Burial Permit Officer

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to July 28, 1923, that I last saw h[illegible] alive on July 25, 1923, and that death occurred, on the date stated above, at 7:20a m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation following coughing attack.

(duration) few minutes, yrs. mos ds.

CONTRIBUTORY (Secondary) Sarcoma in neck

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of June 15, 1923

Was there an autopsy? No

What test confirmed diagnosis? Path. Specimen

(Signed) E H Hayward, M. D.

, 19 (Address) 23 E Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	7/31 1923
20 UNDERTAKER Henry W. Mears & Son	ADDRESS 805 N. Calvert

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE D77906

D77906

CERTIFICATE OF DEATH.

7

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeths Home ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Green

(a) RESIDENCE. No. St. Elizabeths' Home ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) UNK.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
2	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph Green

11 BIRTHPLACE OF FATHER (city or town) Savannah Ga.
(State or country)

12 MAIDEN NAME OF MOTHER Lucy Williams

13 BIRTHPLACE OF MOTHER (city or town) Savannah Ga.
(State or country)

11 Informant
(Address)

15 Filed [illegible] 19 [illegible] Registrar

Burial Permit Cl[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1923

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1923, to July 28, 1923, that I last saw h[illegible] alive on July 27, 1923, and that death occurred, on the date stated above, at 4.45A. m.

The CAUSE OF DEATH* was as follows:

Measles (duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchs Pneumonia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd M. D.

July 28, 1923 (Address) 2006 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL DATE OF BURIAL

JOHNS HOPKINS HOSPITAL 19

20 UNDERTAKER ADDRESS

Consolidated Funeral Home

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation may be very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77907

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D77907

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 131 E. Central Av St., WARD)

2-FULL NAME Lorenz Fleischmann

(a) RESIDENCE No. 131 E. Central av St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Eva E. Fleischmann

6 DATE OF BIRTH (month, day, and year) June 25/48

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Woodworker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Fleischmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Eva E. Fleischmann

(Address) 131 N. Central av

Robert J. Garrick

Filed JUL 30 1923 Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1923

17

I HEREBY CERTIFY, That I attended deceased from July 19 1923 to July 28 1923 that I last saw him alive on July 27 1923 and that death occurred, on the date stated above, at 9 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) mos. yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Laboratory

(Signed) A F Rein M. D.

July 29 1923 (Address) 24 E Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL 7/30 1923

20 UNDERTAKER Philip Herring — ADDRESS 2016 Aiken

...E.—WRITE PLAINLY, WITH CRAYON OR INK. ...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77908 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77908

CERTIFICATE OF DEATH. 91-002

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., WARD)

2-FULL NAME James Phillips

(a) RESIDENCE NO. Bay View Asylum ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) [illegible] 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed ..... 19 ..... Registrar

Robert F. Morrison

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 19 23

17 I HEREBY CERTIFY, That I attended deceased from August 13 19 18 to July 29 19 23.

that I last saw him alive on July 29 19 23.

and that death occurred, on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:

Exsuccation; arteriosclerosis; myocardial fibrosis; pulmonary congestion and edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Goldsmith M. D.

7-30-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Aug 1 1923

UNDERTAKER Govan & Love

ADDRESS Govan & Love

Govan & Love

Jos. Sollins Jr

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN should state EXACTLY. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D77909 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77909

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 313 W. 30th. Street St., 17 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Francis Hare

(a) Residence No. 313 W. 30th. St. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct. 23, 1922

7-AGE.	If LESS than 1 day.
....yrs. 9 mos. 6 ds.	....hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS:
10-NAME OF FATHER, John J. Hare
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.
12-MAIDEN NAME OF MOTHER, May Burke
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md.

14- (Informant) John J. Hare.
(Address) 313 W. 30th. Street

15- Filed ... Robert P. Harrison. Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 29, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 19, 1923 to July 29, 1923
that I last saw him alive on July 29, 1923
and that death occurred, on the date stated above, at 3. P. m.
The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) yr. mos. 3 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Coolahan, M. D.

7/30, 1923 (Address) 24 N. Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral	July 31, 1923
20-UNDERTAKER. John F. Logan & Son Per J. F. Logan	ADDRESS. 901 Gallows St.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77910

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77910

CERTIFICATE OF DEATH.

113

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Kessler

(a) RESIDENCE NO. 230 N. Dickeman ST., WARD 10

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 18, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
		2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Christopher Kessler

11 BIRTHPLACE OF FATHER (city or town).....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Letitia Miller

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Letitia Kessler
(Address) 419 S Poppleton st

15 Filed ..... Robert P. Garrison, Registrar

JUL 30 1923

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1923

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1923, to July 30, 1923, that I last saw him alive on July 30, 1923 and that death occurred, on the date stated above, at 12:40 P.m.

The CAUSE OF DEATH* was as follows:

Intestinal hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute intestinal indigestion with duodenal ulcer (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) ..... M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL July 31 1923

20 UNDERTAKER George J Smith

ADDRESS 153 Hollins

N.B.—WHITE PAPER, with heavy surface, should be used. AGE should be stated EXACTLY. PHYSICIAN should write plainly. AGE should be carefully supplied. Exact statement of OCCUPATION should be given, so that it may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec— 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77911 X 73 D77911

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mercy Hospital St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Michael Ripla

(a) Residence No. S. S. Letthorn St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. ..... mos. 24 ds. How long in U. S., if of foreign birth? yrs. ..... mos. 7 ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word)
Male	White	[illegible]

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1889.

7-AGE.	If LESS than 1 day,
34 yrs. ..... mos. ..... ds.	..... hrs. or ..... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Sailor.
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) Norway.
(State or Country),

PARENTS.

10-NAME OF FATHER. Christian Ripla

11-BIRTHPLACE OF FATHER (city or town) Norway
(State or Country),

12-MAIDEN NAME OF MOTHER. Anna.

13-BIRTHPLACE OF MOTHER (city or town) Norway
(State or Country),

14- (Informant) Hospital Records

(Address).....

15- Filed ..... 192 Robert F. Harrison., Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/30/23

17- I HEREBY CERTIFY, That I attended deceased from 7/20/23, 19 ..... to 7/29/23, 19 .....
that I last saw h[illegible] alive on 7/29/23 19
and that death occurred, on the date stated above, at 9:10 a. m.
The CAUSE OF DEATH* was as follows:

Chr. Ant. Poliomyelitis

?
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Paralysis of Respir. Centr.
6 hrs (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) K. W. Holley M. D
, 19 (Address) Mercy Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Dallastown	July 31, 1923
20-UNDERTAKER.	ADDRESS
Cobb & Hunter	144 W. Bway

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77912

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 151 D77912

1-PLACE OF DEATH University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME James Key

(a) RESIDENCE NO. Westminster Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) unknown

PARENTS

10 NAME OF FATHER James Key

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Virginia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant F. Reese
(Address) Westminster Md

15 Filed ..... 19 .....
ROBERT P. MORTIMER,
Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 24th 1923

17

I HEREBY CERTIFY, That I attended deceased from May 19th, 1923, to July 24th, 1923, that I last saw him alive on July 24th, 1923, and that death occurred, on the date stated above, at 5 P.m.

The CAUSE OF DEATH* was as follows:

Toxemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Gangrene

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical findings.

(Signed) J. F. White, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Md	Aug 1 1923
20 UNDERTAKER W M Routson	ADDRESS 230 N Greene

UL 30 1923

NOTE should be stated EXACTLY. PHYSICIAN should state AGE should be carefully supplied. AGE should be stated mation should be carefully supplied. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77913

CERTIFICATE OF DEATH.

90 D77913

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1405 Riverside Ave. ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George A. Meridith.

(a) RESIDENCE No. 1405 Riverside Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 3 mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~WIFE of~~ Lottie Meridith.

6 DATE OF BIRTH (month, day, and year) April 23, 1870.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	3	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Boilermaker.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER August R. Meridith.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Harriet A. Coleman.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Kate Ferguson. (sister).
(Address) 1405 Riverside Ave.

15 JUL 30 1923 192 Robert P. Harrison, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Otto M. Reinhardt, M. D. (Coroner.)

July 28, 1923 (Address) 1014 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	July 31 1923
20 UNDERTAKER John F. Denny	ADDRESS 715 Lights

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77914

D77914

CERTIFICATE OF DEATH. 164

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2308 W.Fayette St. ST., WARD)

2-FULL NAME Lucy Billups Rosewag

(a) RESIDENCE NO. 2308 W.Fayette St. ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Rosewag

6 DATE OF BIRTH (month, day, and year) Sep't 20 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	85	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Eva Dolle

(Address) 2308 W.Fayette St.

Filed JUL 30 1923 ..19.. Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1923

17 I HEREBY CERTIFY, That I attended deceased from July 21st, 1923, to July 25th, 1923, that I last saw her alive on July 27th, 1923, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows: General Debility

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 15 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Jno. F. Alma M.D.

7/30, 1923 (Address) 220 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL July 31/1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Lafayette

A—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation should be given. AGE may be properly classified. Exact statement of Occupation should be given. AGE may be properly classified. Exact statement of Occupation should be given. AGE

Spec.—1-10-21—M&T—1500 Bks.

D77915

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77915

CERTIFICATE OF DEATH.

75-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Belair Road near Southern Ave. ST., Gardenville (WARD) 17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME George Hofstetter

(a) RESIDENCE NO. Belair Road near Southern ave. ST., Gardenville WARD

(Usual place of abode) (If not resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Hofstetter

6 DATE OF BIRTH (month, day, and year) June 17th 1835

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
88	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Truck Farm

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balty. Co. Maryland

PARENTS

10 NAME OF FATHER Joseph Hofstetter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Unknown

14 Informant Katherine Hofstetter (Address) Gardenville Md.

15 Robert F. Harrison, Registrar

JL 31 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1923

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1923, to July 28, 1923, that I last saw h live on July 28, 1923 and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis of lower extremities

Contributory (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Symptoms of

(Signed) Wm D Carey M. D.

, 19 (Address) Carey & Southern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	July 31 1923
20 UNDERTAKER	ADDRESS
Fred'k Lassahn & Sons	Fullerton

8.—WRITE PLAINLY. Ink should be used. AGE should be stated EXACTLY. PHYSICIAN should give information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77916

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77916

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST., WARD)

2-FULL NAME Mr. Charles A. Luck.

(a) RESIDENCE NO. 652 N. Franklin, Balto ST., WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred 5-2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced (or) WIFE of Margaret Farrow Luck.

6 DATE OF BIRTH (month, day, and year) 10/13/1870

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Druggist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. S.

PARENTS

10 NAME OF FATHER Albert Luck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant The Patient.
(Address)

15 July 30 1923 Robert F. Harrison, Registrar
Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1923

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1923, to July 28, 1923, that I last saw him alive on July 28, 1923, and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:
Carcinoma of stomach.

(duration) 3+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal bronchopneumonia (duration) yrs. four hours. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/23

Was there an autopsy? No

What test confirmed diagnosis? Operation, exploratory.

(Signed) Jno. T. Finney Jr., M. D.

July 28 1923 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park ~~Cemetery~~ Cemetery

DATE OF BURIAL July 31 1923

20 UNDERTAKER H. Allen Fuller

ADDRESS 2702 Gerrish Ave

JUL 30 1923

G. B.—WRITE LEGIBLY, WITH INDELIBLE INK. All items should be stated EXACTLY. PHYSICIAN'S ... AGE should be carefully supplied. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. (Dorothy Hyser)

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77917 D77917

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 So Vincent St., WARD 10)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Hyser

(a) RESIDENCE No. 410 So Vincent St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 31/18

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Chas Hyser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Queen Anne County Md

12 MAIDEN NAME OF MOTHER Faherty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Chas. S Hyser, Jr. (Address) 410 So Vincent St

15 [illegible] Registrar

JUL 31 1923

[illegible] Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1923

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1923, to July 29, 1923

that I last saw her alive on July 29, 1923

and that death occurred, on the date stated above, at 4.40 A m.

The CAUSE OF DEATH* was as follows:

Ulcer Colitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theodore Kalamaras, M. D.

(Address) July 30 1735 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL July 31 1923.

20 UNDERTAKER Harry H. Witzke — ADDRESS 1531 W. Lombard St

P. S.—WHITE PAPER, WHITE INK. Only typewriting or pen and black ink should be used. AGE should be carefully supplied. AGE mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. William H Brook (77918)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77918

CERTIFICATE OF DEATH.

90 D77918

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 519 W Hoffman ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ignatius Brooks

(a) RESIDENCE No. 519 Hoffman ST., WARD

(Usual place of abode) (If not resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary H. Brooks

6 DATE OF BIRTH (month, day, and year) Jan 2, 1873

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
50	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) Barber

(c) Name of employer George Pelzer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Albert George Brooks

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Lydia Spurrier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mary H. Brooks (Address) 519 W. Hoffman St

15 JUL 31 1923 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1923

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1923, to July 28, 1923, that I last saw him alive on March 27, 1923 and that death occurred, on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Cardiac Renal

(duration) — mo. 6 mos — da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John C Stewart, M. D.

, 19 (Address) 724 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	July 31 1923

20 UNDERTAKER John A Bishop & Son, by W. Norman Bishop — ADDRESS 1109 Druid Hill Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77919

CERTIFICATE OF DEATH. X 117

D77919

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., WARD) 11

2-FULL NAME Emmaleje Winder

(a) RESIDENCE NO. Rutherville, Md ST., WARD.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Winder

6 DATE OF BIRTH (month, day, and year) March 5, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Leno Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Estella Scott

(Address) 1733 McCulloh St

15 Filed JUL 31 1923 19 ROBERT R. KRAUTH Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 26th, 1923, to July 28th, 1923, that I last saw her alive on July 27th, 1923, and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Diabetic Coma. (duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 3/17/23

Was there an autopsy? No

What test confirmed diagnosis? Urine Examination

(Signed) Harry F Brown, M. D.

7/28 1923 (Address) 1501 Presstman st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudy Green Cem | DATE OF BURIAL July 31 1923

20 UNDERTAKER Samuel S Hendley | ADDRESS 73

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Lanzell.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77920

CERTIFICATE OF DEATH.

90

D77920

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1930 Brunt St ST., WARD) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nancy Langell

(a) RESIDENCE No. 1930 Brunt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-4-1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co Md

PARENTS

10 NAME OF FATHER Henry Wenby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbot Co Md

12 MAIDEN NAME OF MOTHER Matilda Tolly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbot Co Md

14 Informant Viola Lanzell

(Address) 1930 Brunt St

15 Filed JUL 31 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/29 19 23

17 I HEREBY CERTIFY, That I attended deceased from March 4 1922 to July 29 1923.

that I last saw h— alive on July 29 1923

and that death occurred, on the date stated above, at 5-20 m.

The CAUSE OF DEATH was as follows:

Mitral Insuf.

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs 3 mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Walter J. Dorsey, M. D.

, 19 (Address) 16 Bell-Mulkern St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 7/31 19 23

20 UNDERTAKER Samuel J Wensley — ADDRESS 538 N Bdle

N. B.—WRITE LEGIBLY, WITH UNFADING INK. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77921

CERTIFICATE OF DEATH.

36-005

D77921

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Mary's Ind. Sch. ST., WARD)

2-FULL NAME Merideth Taliaferro

(a) RESIDENCE NO. Louisa Co. Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 12-1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown Va

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Chas Taliaferro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Esther Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant, Annie Taliaferro

(Address) Zion St. Louisa Co Va

15 JUL 31 1923 ROBERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1923

17 I HEREBY CERTIFY, That I attended deceased from April 9 , 1921 , to July 29 , 1923.

that I last saw him alive on July 28 , 1923,

and that death occurred, on the date stated above, at 8:45 a m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Larynx

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) O Stonecipher, M. D.

, 19 (Address) St Mary's Ind Sch Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Louisa Co Va — DATE OF BURIAL: July 31 1923

20 UNDERTAKER: Reid & Hensley — ADDRESS: Balto

N. B.—WHAT DISEASE, injury, or complication should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77922 .

D77922

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital. ST., WARD)

2-FULL NAME Alice Reddicks

(a) RESIDENCE NO. 505 W. Baratoga St. ST., WARD ...

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER Alexander Ashby

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Agnes Miles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Municipal Hospital Records.
(Address)

15 Filed JUL 31 1923 ROBERT R. KRAMER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1923

17

I HEREBY CERTIFY, That I attended deceased from July 16, 1923, to July 28, 1923.

that I last saw h er alive on July 28, 1923

and that death occurred, on the date stated above, at 9:45 P.M.

The CAUSE OF DEATH* was as follows:

immediate cause Uremia; chronic nephritis.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis; Chronic

~~My~~ condition (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) N. Goldsmith M. D.

7-30-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Alexandria, Va	July 31 1923

20 UNDERTAKER Samuel Hensley Wheeler ADDRESS 537

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Victoria Vilkauckas) ✓

D77923

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001. D77923

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2211 Shore ST., 25 WARD) Vilkauckas Morrell Pk.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Victoria Vilkaucka (Morrell Park)

(a) RESIDENCE NO. 2211 Shore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30 1923

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto md (State or country)

PARENTS

10 NAME OF FATHER John Vilkaucka

11 BIRTHPLACE OF FATHER (city or town) Balto md (State or country)

12 MAIDEN NAME OF MOTHER Margt Marcus

13 BIRTHPLACE OF MOTHER (city or town) Balto md (State or country)

14 Informant John Vilkaucka (Address) 2211 Shore St

15 JUL 31 1923 ROBERT R. KRAUTH Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1923

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1923, to July 30, 1923, that I last saw h er alive on July 30, 1923 and that death occurred, on the date stated above, at 10-30 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) some

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Dr. M. Duffee M. D.

July 30 23, 19 (Address) 2328 Edmondson Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL July 31 1923

20 UNDERTAKER John Grebliunas — ADDRESS 425 S. Paca

N.B.—WRITE PLAINLY, with ink or indelible pencil. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77924

CERTIFICATE OF DEATH. 122-001

D77924

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1408 N. Bethel ST., (WARD)

2-FULL NAME Frank Schmidtman

(a) RESIDENCE NO. 1408 N. Bethel ST., WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 8 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ida L. Schmidtman

6 DATE OF BIRTH (month, day, and year) Nov. 20 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... mm.
	64	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood carver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs. Ida L. Schmidtman

(Address) 1408 N. Bethel St

15 Filed ..., 19... ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 14, 1922, to July 30, 1923

that I last saw h[illegible] alive on July 30, 1923

and that death occurred, on the date stated above, at 12 [illegible] P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Liver Hypertrophic

(duration) 4 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) ... yrs. ... mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Denis Milan, M. D.

, 19 (Address) 1506 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County — DATE OF BURIAL: Aug. 1 1923

20 UNDERTAKER Henry Hoeck Son — ADDRESS 1201 E. Eager St

A.B.—WRITE PLAINLY, with indelible pencil. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D77925 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77925

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 55 E. Randall Street. ST., WARD) 43

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ottilia A. Schmaltz.

(a) RESIDENCE NO. 55 E. Randall ST. Street. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. --- mos. --- ds. How long in U. S., If of foreign birth? 36 yrs. --- mos. --- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a If married, widowed, ~~or divorced~~
~~HUSBAND OF~~
(or) WIFE of Robert Schmaltz.

6 DATE OF BIRTH (month, day, and year) April 14, 1862.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	3	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany.

PARENTS

10 NAME OF FATHER ---- Knopp.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Elizabeth Watts. (daughter).
(Address) 55 E. Randall Street.

15 [redacted] Burial Permit

JUL 31 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29, 1928.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the heart and Kidneys.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto H. Leinhardt M. D.
(Coroner.)

July 30, 1928 (Address) 1019 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL July 31 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D77926

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

D77926

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Municipal Hospital. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas D. Porter

(a) Residence No. 25 Locust St., Curtis Bay St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1857

7-AGE. 66 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER. John Porter

11-BIRTHPLACE OF FATHER (city or town) (State or Country). England

12-MAIDEN NAME OF MOTHER. ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore, Md.

14- (Informant) Municipal Hospital Records

(Address)

15- JUL 31 1923 ROBERT N. KRAMER Registrar.

Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 30, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 28, 1923 to July 30, 1923

that I last saw h. im alive on July 30, 1923

and that death occurred, on the date stated above, at 9:10 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(Duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(Duration) — yrs. — mos. 3 ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. [illegible] M. D.

7-30-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Cedar Hill	Aug 1 1923
20-UNDERTAKER, John F Berry	ADDRESS, 415 Light St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Bks.

D77927 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77927

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 1018 W Cross St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maurice F Harman

(a) Residence No. 1018 W Cross St., 21 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE White | 5-SINGLE, MARRIED, WIDOWED, or DIVORCED (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or WIFE of) Edna

6-DATE OF BIRTH (month, day and year) Oct 14-1888

7-AGE 34 yrs. 9 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Jacobsburg Md

PARENTS.

10-NAME OF FATHER Jos J Harman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER Emma Kirkland

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) E. Harman

(Address) 1018 W Cross

15- Filed ..... 192.... ROBERT R. KRAMER Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 29 1923

17- I HEREBY CERTIFY, That I attended deceased from Nov. 1922 to July 29 1923

that I last saw him alive on July 29 1923

and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Phthisis Pneumonia

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? none

Did an operation precede death? none Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) John C Schwarzmann M. D.

(Address) 1170 W Cross St

*State the **Disease causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park Cem	Aug 31 1923
20-UNDERTAKER.	ADDRESS
Jos Joesdens Son	217 S Bcca

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Stoc—12-23-21—E.B.R.S.—400 Bks.

D77928 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77928

88

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1721 Moreland ave St., 11 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Volker

(a) Residence No. 1721 Moreland St., 11 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 3 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of the late George J. Volker

6-DATE OF BIRTH (month, day and year) Apr 1st 1857

7-AGE, 66 yrs. 3 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of industry, business, or establishment in which employed (or employer)... none

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore City Md

PARENTS.

10-NAME OF FATHER, Philip Nagel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Don't Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Germany

14- (Informant) Philip J. Volker

(Address) 1721 Moreland ave

15- Filed ....192.. ROBERT R. KRE... Burial Permit ...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 28th 1923

17- I HEREBY CERTIFY, That I attended deceased from July 7 1923 to July 28 1923 that I last saw h.. alive on July 28 1923 and that death occurred, on the date stated above, at 1058 m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) ...yrs. 1 mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ... mos. ...ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C V Lloyd M. D.

, 19 (Address) 1732 Eutaw pl

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	July 31st 1923
20-UNDERTAKER.	ADDRESS
Geo Weber & Son	2503 Elmondrop ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77929

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002 D77929

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 503 S. Chapel ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas A. Krusniewski

(a) RESIDENCE NO. 503 S. Chapel ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15th 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
			18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Krusniewski

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Maryorie L. Mills

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Thomas A. Mills.
(Address) 503 S. Chapel St

15 Filed . 19 ROBERT R. KRAUSE Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30th 1923

17

I HEREBY CERTIFY, That I attended deceased from 7-25 , 1923, to July 30 , 1923

that I last saw him alive on July 29 , 1923,

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Lesion

(duration) yrs. mo 18 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) [illegible] M. D.

, 19 (Address) 1000 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	July 31st 1923
20 UNDERTAKER Lilly & Siler	ADDRESS 403 S. Wolfe

N. B.—WRITE PLAINLY. Without erasures or abbreviations. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Charles Platzer

D77930 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 D77930

1-PLACE OF DEATH Bay View Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Edward Platzer 14

(a) RESIDENCE No. 1117 Fremont Ave ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred fife yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Broom - Maker
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant Bay View Hospital
(Address) .....

15 Filed AUG 3 1923 ROBERT R. KRAMER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30. 1923

17 I HEREBY CERTIFY, that I attended deceased from May 18, 1923 to July 30 1923
that I last saw him alive on July 30 1923
and that death occurred, on the date stated above, at 11.49 a.m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (terminal)

(duration) ..... yrs. 2 mos. 12 ds.

CONTRIBUTORY (Secondary) Myocarditis & Cirrhosis
(duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical Findings

(Signed) N. Goldsmith, M. D.
8/3/1923 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Aug 1 1923
20 UNDERTAKER	ADDRESS
Walter W. Skinner	1018 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS BLANK MUST BE FILLED OUT COMPLETELY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Died July 31-1923 D77931

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77931

CERTIFICATE OF DEATH. 159-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3957 Greenmount ave ST., ... WARD) 9

2-FULL NAME Fred allen Swift.

(a) RESIDENCE NO. 3951 Greenmount ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 28-23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			2/12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Jno. allen Swift.

11 BIRTHPLACE OF FATHER (city or town) Littlestown
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Mildred Wrikut 7-31-1923

13 BIRTHPLACE OF MOTHER (city or town) Littlestown
(State or country) Pa.

14 Informant Jno. allen Swift.
(Address) 3951 Greenmount ave

15 Filed JUL 31 1923 ROBERT A. KRAMER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1923

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1923, to July 31, 1923, that I last saw him alive on July 31, 1923, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:
Congenital Malformation of Heart.

(duration) ..... yrs. mos 2/12 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. mos. da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H C Kees. , M. D.

7-31, 1923 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Lukes, Littlestown Pa

DATE OF BURIAL July 31 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E York

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77932 ✓ D77932

CERTIFICATE OF DEATH.

57

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Balto. General Hospital. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah McClean

(a) RESIDENCE NO. 3025 Elliott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 6 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced (or) ~~HUSBAND of~~ WIFE of Joseph. F. McClean

6 DATE OF BIRTH (month, day, and year) Jan 9-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife-

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Self-

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland.

PARENTS

10 NAME OF FATHER John M. Martin

11 BIRTHPLACE OF FATHER (city or town) Balto, (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Kaiser

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Mrs. Mary Beynon

(Address) 2419 E. Lafayette Ave

15 JUL 31 1923 ROBERT R. KRAUTER, Registrar Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1923

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1923, to July 29, 1923, that I last saw her alive on July 25, 1923, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 3 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3025 Elliott St

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John L. Fenby, M. D.

7/29, 1923 (Address) 3522 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Aug 1923

20 UNDERTAKER Zerkel + Zirkle — ADDRESS 1739 E. Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77933

CERTIFICATE OF DEATH.

44 D77933

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 510 N. Glover ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agusta Hoffman

(a) RESIDENCE NO. 510 N. Glover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced, (write the word)~~ ~~Married~~.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Hoffman

6 DATE OF BIRTH (month, day, and year) Dec. 1859.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Martin Schulz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Schmolz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Marie Johnson

(Address) 510 Glover St

15 Filed JUL 31 1923 ROBERT R. KRAUTH Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1923

17

I HEREBY CERTIFY, That I attended deceased from July 28 1923 to July 30 1923.

That I last saw h[illegible] alive on July 29 1923,

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of stomach.

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) L. Steinhart, M. D.

19 (Address) 4-4-791 Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 1 1923

20 UNDERTAKER L. Kemmerer ADDRESS 22 D Baltimore

Spec.—1-10-21—M&T—1500 Bks.

D77934 HEALTH DEPARTMENT—CITY OF BALTIMORE D77934

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 8

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2207 Hanford ST. AW WARD)

2-FULL NAME Mary A. Blum

(a) RESIDENCE NO. 2207 Hanford ST. (AW) WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND (of) WIFE of Joseph A Blum

6 DATE OF BIRTH (month, day, and year) Oct 28 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John O'Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Henrietta Amos

12 MAIDEN NAME OF MOTHER Hopkins Md

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Regina Mergl

(Address) 2207 Hanford St

15 JUL 31 1923 ROBERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1923

I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to July 30, 1923,

that I last saw him alive on July 29, 1923,

and that death occurred, on the date stated above, at 11:15 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine M. D.

(Address) 14 S. Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Aug 1, 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 Park

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See Instructions on back of certificates. Exact statement of OCCUPA-

Spec.—1-10-21—M&T—1500 Blks.

D77435

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77435

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3229 E Baltimore ST., ... WARD)

2-FULL NAME William H. Johnson

(a) RESIDENCE NO. 3229 E Baltimore ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

Single, married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Simms

6 DATE OF BIRTH (month, day, and year) Mar 16, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Real Estate

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Benjamin Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Henriette Hanson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary J. Johnson

(Address) 3229 E Baltimore St

15 JUL 31 1923 ROBERT R. KRAMER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/30 1923

17

I HEREBY CERTIFY, That I attended deceased from Mar 8, 1923, to July 30, 1923, that I last saw h[illegible] alive on July 29, 1923, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Acd. Pulm. Oedema.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophy (Apoplexy) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wright B. Dudley, M. D.

7/30, 1923 (Address) 3323 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug 1st 1923
20 UNDERTAKER	ADDRESS
C. J. Fanning & Son	1461 Battery Ave.

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. Information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77936

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

94-001 D77936

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 W. Hughes ST., (WARD) 17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bonner

(a) RESIDENCE NO. 126 W. Hughes ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Charles Bonner

6 DATE OF BIRTH (month, day, and year) July - 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	59	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Greenesville Co.
(State or country) Virginia

PARENTS

10 NAME OF FATHER Jim Roberts

11 BIRTHPLACE OF FATHER (city or town) unknown.
(State or country)

12 MAIDEN NAME OF MOTHER Betsy

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Joseph Bonner
(Address) 126 W. Hughes St.

15 Filed JUL 31 1923 by ROBERT N. KRAMER, Registrar

Burial Permit [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July, 29, 1923

17

I HEREBY CERTIFY, That I attended deceased from July, 1, 1923, to July, 29, 1923, that I last saw her alive on July, 28, 1923, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) — yrs. — mos. 29 ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis + Nephritis

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? urine - positive

(Signed) David Franklin M. D.

7/30, 1923 (Address) 122 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 2, 1923
20 UNDERTAKER	ADDRESS
Chas H. Alexander	2126 Druid Hill Ave

N. B.—WRITE PLAINLY, with pen and ink. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77937

D77937

CERTIFICATE OF DEATH.

45

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1921 E Lafayette ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Willingham

(a) RESIDENCE NO. 1921 E Lafayette ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. (if of foreign birth)? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of John F Willingham

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland Ireland

PARENTS

10 NAME OF FATHER John Burke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Winifred Flemming

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Gertrude Willingham

(Address) 1921 E Lafayette ave

15 Filed JUL 31 1923 19 ROBERT R. KRAMER, Registrar

Burial Permit [redacted]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1 1922 to July 27 1923

that I last saw her alive on July 27 1923

and that death occurred, on the date stated above, at 11 PM m.

The CAUSE OF DEATH* was as follows:

Cancer of uterus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. Blyward Burdock M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Aug 1st 1923

20 UNDERTAKER C D Fleming

ADDRESS Nov-1938 Lafayette Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77938

CERTIFICATE OF DEATH.

74-001 D77938

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3101 Guilford Avenue ST., ... WARD)

2-FULL NAME Anna E. Macdonald

(a) RESIDENCE NO. 3101 Guilford Avenue ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 8 mos. 21 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H. Macdonald

6 DATE OF BIRTH (month, day, and year) Nov. 7, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George F. Grothaus

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Wessler

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Gordon Macdonald
(Address) 3101 Guilford Avenue

15 Filed JUL 31 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 28 28 July 1923

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1922, to July 27, 1923.

that I last saw h alive on July 27, 1923

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage Brain

Hemiplegia

(duration) One yrs. 2 mos. 22 ds.

CONTRIBUTORY (Secondary)

(duration) One yrs. 2 mos. 22 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) John F. Edelberg M. D.

July 30 1923 (Address) 1810 E Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 7/31 1923

20 UNDERTAKER Henry W. Mears & Son

ADDRESS N. Calvert

N. B.—WRITE PLAINLY WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77939

CERTIFICATE OF DEATH.

D77939

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST. 28 WARD)

2-FULL NAME Mrs Myrtle B. Miller -

(a) RESIDENCE. No. Mt Hope Retreat ST. 28 WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married -

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Mr Miller

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
abt	53	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (?)
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Shank -

11 BIRTHPLACE OF FATHER (city or town) Waynesboro
(State or country) Pa

12 MAIDEN NAME OF MOTHER (?) Shank

13 BIRTHPLACE OF MOTHER (city or town) Waynesboro
(State or country) Pa

14 Informant Records of Mt Hope Retreat
(Address) Mt Hope Md -

15 Filed ..... 19 ..... ROBERT R. KRAMER,

JUL 31 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1923

17

I HEREBY CERTIFY, That I attended deceased from May 19 1918, to July 30 1923, that I last saw her alive on July 30 1923, and that death occurred, on the date stated above, at 12 midnight m.

The CAUSE OF DEATH* was as follows:

Chr. Diabetes

over (duration) 5 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Man Dep. Psychosis (Diabetes) (duration) 5 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Waynesboro Pa

Did an operation precede death? No Date of 0

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Hill Pa	July 31 1923

20 UNDERTAKER ADDRESS

Wm J Hitchcock Jr Mark & Pleasures

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77940 D77940

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St.,.....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Ferguson

(a) Residence No. 1728 E. Pratt St. St.,.....Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1852

7-AGE. 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, James Ferguson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Municipal Hospital Records

(Address)

15- JUL 31 1923 1923 Robt P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 27, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 16 19 23 to July 27 19 23

that I last saw him alive on July 27 19 23

and that death occurred, on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab + X-ray

(Signed) Claude G. Hume M. D.

7-28-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, ... 19....
20-UNDERTAKER.	ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health.

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77941

D77941

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bennett

(a) RESIDENCE NO. 510 Greenwillow ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/30/23

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Alex Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Mary's Co Md

12 MAIDEN NAME OF MOTHER Nellie Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Robert P. Harrison, (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 31 1923 Burial Permit Clerk. Registrar

0.702

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1923

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1923, to July 30, 1923,

that I last saw him alive on July 30, 1923;

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature Sy.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	3 19
20 UNDERTAKER	ADDRESS

—WRITE PLAINLY, WITH PENCIL OR PEN. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77942

CERTIFICATE OF DEATH.

91-002 D77942

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 412 N Collington Ave St.

(WARD) 6

2-FULL NAME Sarah Ellen Warner

(a) RESIDENCE NO. 412 N. Collington Ave St.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James N Warner

6 DATE OF BIRTH (month, day, and year) March 3 40

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Home Work

(c) Name of employer at Home

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Abraham Weaver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Fantz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Henry Biskenstock (Address) 342 W Collington

15 JUL 18 1923 Robert P. Harrison Registrar

Burial Permit Cl[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 16th 19 23, to July 30th 19 23,

that I last saw her alive on July 30th 19 23,

and that death occurred, on the date stated above, at 3.30 a m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Cannot say definitely

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Sol Kolmer, M. D.

July 31 1923 (Address) 1 So. Eden Cap 1186

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md

DATE OF BURIAL Aug 1 1923

20 UNDERTAKER W. M. Rowlson

ADDRESS 223 S Mt

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... matlon should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Preston)

HEALTH DEPARTMENT--CITY OF BALTIMORE ✓

D77943 D77943

144

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hospital St. WARD) 13

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Clara G. Purdom

(a) RESIDENCE NO. 3609 Maple Ave. ST., Balto Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 6 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jas Henry Purdom

6 DATE OF BIRTH (month, day, and year) 1-20-1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	30	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Andrew Thomas Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Hester A. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Husband. (Address)

15 Filed ..... 19 ..... Robert P. Harrison Registrar

Burial Permit Cl[illegible].

JUL 31 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-30-23

17 I HEREBY CERTIFY, That I attended deceased from 7-30-23, 19 , to 7-30-23, 19 , that I last saw h[illegible] alive on 7-30-23, 19 , and that death occurred, on the date stated above, at 6 05 m.

The CAUSE OF DEATH* was as follows:

Pregnancy

(duration) yrs. 9 mos — ds.

CONTRIBUTORY (Secondary) Post Partum Hemorrhage

(duration) yrs. P.P.H. mos. 1 hr.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? Yes Date of 7-30-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Jno A Tompkins M. D.

. 19 (Address) 20 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
St. Marys, Hampden	Aug 2 1923
20 UNDERTAKER	ADDRESS
Horace H. Burgee	363 Fall Rd.

B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77944

CERTIFICATE OF DEATH.

D77944

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Burns

(a) RESIDENCE NO. 145 N. Streeper St ST., WARD 6
(Usual place of abode)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1838

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER T. Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Municipal Hospital Records. (Address)

15 Filed ..... 19 ..... Registrar

JUL 31 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1923 to July 29, 1923, that I last saw him alive on July 29, 1923, and that death occurred, on the date stated above, at 9:45 P.M.

THE CAUSE OF DEATH* was as follows:

Fracture of ribs - accidental
(fall overboard, striking wooden [illegible], and protruding nails)
(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (secondary) Bronchopneumonia.
(duration) ... yrs. ... mos. 2 ds.

18 Where did this disease contracted if not at place of death? .....

Did operation precede death? No. Date of .....

Was there an autopsy? Yes.

What confirmed diagnosis? Autopsy.

(Signed) Wm. J. Faulton, M. D.

7/30/23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

CORONER FOR BALTIMORE CITY EASTERN DISTRICT.

19 PLACE OF BURIAL, CREMATION OR REMOVAL. St. Patricks bcmt. DATE OF BURIAL Aug 1 1923

20 UNDERTAKER Winbrook ADDRESS 502 E York

N. B.—WRITE PLAINLY, WITH UNFADING INK—AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77945

CERTIFICATE OF DEATH.

113

D77945

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Gallion

(a) RESIDENCE NO. 1835 Lemmon ST., WARD 11

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 17 /23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Clarence Gallion

11 BIRTHPLACE OF FATHER (city or town) (State or country) Newark New Jersey

12 MAIDEN NAME OF MOTHER Julia E. Gallion

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs Gallion (Address) 1835 Lemmon St

15 Robert F. Harrison Registrar

JL31 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1923

17

I HEREBY CERTIFY, That I attended deceased from July 28, 1923, to July 30, 1923, that I last saw h alive on July 30, 1923, and that death occurred, on the date stated above, at 6:40 A.m.

The CAUSE OF DEATH* was as follows:

Intestinal indigestion with toxic diarrhoea Malnutrition

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Signs + symptoms

(Signed) R. Bell Jr M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL July 31st 1923

UNDERTAKER F. B. Keppert ADDRESS 2256 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D77946 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77946

CERTIFICATE OF DEATH.

7/4-101

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor) St., (Ward) 10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Sarah Potts

(a) Residence No.... Preston Valley St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single,~~ ~~Married~~ Widowed, ~~or Divorced~~ (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widow of Henry Potts

6-DATE OF BIRTH (month, day and year) 1838

7-AGE. 85 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Wm Wheatley

11-BIRTHPLACE OF FATHER (city or town) (State or Country). —

12-MAIDEN NAME OF MOTHER. Sally Murray

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). —

14- (Informant)..... Sister Superior

(Address)..... Preston Valley Hospital

15- Filed....., 192.... Registrar.

Robert P. Harrison

Burial Permit Given

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 31 1923

17- I HEREBY CERTIFY, That I attended deceased from Dec 1922 to..... 19.....

that I last saw h.. alive on July 29 1923

and that death occurred, on the date stated above, at 2 to P. m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

3 days (Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

July (Signed) J. A. Warner M. D

31 , 19 23 (Address) 1133 Valley St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Pauls Cem DATE OF BURIAL. Aug 3, 1923

20-UNDERTAKER. Young & McCurley ADDRESS Easton Pons Ellwood City

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77947 D77947

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1 S. Magnolia ave. (Hamilton) ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George J. Tierney

(a) RESIDENCE NO. 1 S. Magnolia ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 11 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ the late Mary Tierney

6 DATE OF BIRTH (month, day, and year) Aug 5. 1865

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
57	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Passenger Cond.

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Jno. Tierney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Ella Tierney (Address) Hamilton

15 Filed ..... 19.. Registrar

JUL 31 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to July 29, 1923,

that I last saw h~~e~~ive on July 29, 1923,

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

Indefinite

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Diabetic Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. Campbell M. D.

July 31 1923 (Address) 1444 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL Aug 1 1923

20 UNDERTAKER Margaret A. Flynn ADDRESS 1422 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE MUST BE FILLED OUT BEFORE BURIAL PERMIT IS ISSUED. PHYSICIANS should state information should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

D77948

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77948

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 409 E. Biddle St. St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie P.earl Profit

(Residence in Baltimore: No. 409 E. Biddle S.t. St., yrs. mos. ds.)

10

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	white	widow

6-DATE OF BIRTH. June 26/1879 (Month) (Day) (Year)

7-AGE. 44 yrs. 1 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: AT home
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Kehtucky

PARENTS.

10-NAME OF FATHER, James Treadway

11-BIRTHPLACE OF FATHER, (State or Country). Ky.

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country). "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Profit

(Address) 409 E Biddle St.

15-

Filed JUL 31 1923, 192.... Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 30/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) unknown

(Duration) yrs. mos. ds.

(Signed) J. E. Miller M. D.
(Coroner.)

7/31/23 192.... (Address) 508 E. North A

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

London Park Cem 1923

20-UNDERTAKER. ADDRESS

Wm Cook 502 E North Av

CAUTION—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D77949 HEALTH DEPARTMENT—CITY OF BALTIMORE D77949

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. Mercy Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Morris.

(a) Residence No. York Road Forest St., Md Ward Towson Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1907

7-AGE	If LESS than 1 day
16 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer

9-BIRTHPLACE (city or town) Md (State or Country),

PARENTS.

10-NAME OF FATHER, Wm Morris

11-BIRTHPLACE OF FATHER (city or town) Md (State or Country),

12-MAIDEN NAME OF MOTHER, Belle Caples

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country),

14- (Informant) Hospital Record

(Address)

15- Filed ..., 192.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 7/31/23

17- I HEREBY CERTIFY, That I attended deceased from 7/26/23, 19.. to 7/31/23, 19..

that I last saw h[illegible] alive on 7/30/23, 19..

and that death occurred, on the date stated above, at 6.40 a. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

?

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) K. W. Hollay M. D.

, 19 (Address) Mercy.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Prospect Hill Towson — DATE OF BURIAL, Aug 2, 1923

20-UNDERTAKER, J. Ely Burns Sons — ADDRESS Towson

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D77950

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D77950

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1630 Druid Hill ave ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Frederick

(Residence in Baltimore: No. 1630 Druid hill ave St.; ..... yrs., 4 mos. 21 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	Baby

6-DATE OF BIRTH, Feb. (Month) 9 (Day), 1923 (Year)

7-AGE.	If LESS than 1 day,
..... yrs. 5 mos. 21 ds.	.... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Reuben Fredick

11-BIRTHPLACE OF FATHER (State or Country), Antigua B.W.I.

12-MAIDEN NAME OF MOTHER Rachael Robert

13-BIRTHPLACE OF MOTHER (State or Country), Antigua B.W.I.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Reuben Fredick

(Address) 1630 Druid Hill ave

Filed AUG 1 - 1923, 19.. ROBERT R. KRAUTER, Burial Permit [illegible].

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 31 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 19 1923, to July 30 1923, that I saw her alive on July 30 1923, and that death occurred, on the date stated above, at 2.45 a.m.

The CAUSE OF DEATH* was as follows:

Primary — Gastro-Enteritis

Duration ..... yrs. ..... mos. 11 ds.

Developing into Simple Meningitis

Secondary - Exhaustion

Duration ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary) .....

Duration ..... yrs. ..... mos. 11 ds.

(Signed) L. P. Strong M. D.

7-31-1923 (Address) 506 Hanover st.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery

DATE OF BURIAL, Aug. 1, 1923

20-UNDERTAKER Edward Bryan

ADDRESS 621 Orleans st

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77951 — 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 871 Pierce St ST., WARD 19)

2-FULL NAME Martha Virginia Edwards

(a) RESIDENCE NO. 871 Pierce ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. D77951
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Carey Edwards

6 DATE OF BIRTH (month, day, and year): March 3, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	3	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cook
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS
10 NAME OF FATHER: Benjamin Thomas
11 BIRTHPLACE OF FATHER (city or town) (State or country): Northumberland Co Pa
12 MAIDEN NAME OF MOTHER: Jane Sanks
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Northumberland Co Pa

14 Informant: Lucy Peale
(Address) 1409 N Appleton

15 Filed AUG 1 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 1923

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1923, to July 29, 1923, that I last saw h alive on July 28, 1923, and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?

(Signed) D. V. Knuller M. D.
1923 (Address) 149 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. — DATE OF BURIAL: Aug 1 1923

20 UNDERTAKER: John H. Toadvine — ADDRESS 142 Uhler

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77952

CERTIFICATE OF DEATH.

113. D77952

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 605 Burgundy alley WARD) 11

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clarence Owens

(a) RESIDENCE No. 605 Burgundy ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 30 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Frederick Owens

11 BIRTHPLACE OF FATHER (city or town) Balto City md
(State or country)

12 MAIDEN NAME OF MOTHER Etta Marye

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Etta Owens
(Address) 605 Burgundy alley

15 Filed AUG 1 1923, 192 ROBERT R. KRAMER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, ~~autopsy or~~ inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) 2 yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) yrs. mos. 6 ds.

(Signed) H. H. Preston M. D.
(Coroner.)

8/- , 192 3 (Address) 117 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Aug 2 1923

20 UNDERTAKER John H Soaden — ADDRESS 1112 Linden ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D77953

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D77953

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 Harlem ave ST., 10 WARD)

2-FULL NAME William B. Myer

(a) RESIDENCE NO. 919 Harlem Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marcella Sygnedell Myer

6 DATE OF BIRTH (month, day, and year) June 23 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	80	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER James Myer

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah R. Bradford

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Emma E. Myer (Address) 919 Harlem Ave

15 AUG 1 - 1923 ROBERT R. KRAUTH Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1923

17 I HEREBY CERTIFY, That I attended deceased from May 18th, 1923, to July 31st, 1923, that I last saw him alive on July 31st, 1923, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder, secondary to papilloma of same 7 or 8 years duration.

Say (dutation) yrs. 18 mos ds.

CONTRIBUTORY (Secondary) Profound cachexia from (duration) Say yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. H. Van Ness, M. D.

8/1, 1923 (Address) 1515 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 2 1923

20 UNDERTAKER John O. Mitchell ADDRESS 1201 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77954

HEALTH DEPARTMENT--CITY OF BALTIMORE

D77954

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Womens Hospital ST., WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Thomas Seelman Long

(a) RESIDENCE NO. Chester Pa ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Farwell F. Long.

6 DATE OF BIRTH (month, day, and year): Sept 24, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	26	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Richard B. Seelman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ella Eglehart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Dr A E B Eglehart 100 S Caledonia St

15 AUG 1 - 1923 ROBERT R. KRAUTH Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31 1923

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1923, to July 31, 1923, that I last saw her alive on July 31, 1923, and that death occurred, on the date stated above, at 3:15 a m.

The CAUSE OF DEATH* was as follows:

Encephalitis lethargica

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of July 18, 1923

Was there an autopsy? Yes - (Partial)

What test confirmed diagnosis? Spinal puncture

(Signed) Herman E. Zahniser M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chester Pa

DATE OF BURIAL: Aug 2 1923

20 UNDERTAKER: John A. Mitchell

ADDRESS: 120 N. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE sh CAUSE OF DEATH in plain terms, so that it m TION is very important. See instructions on ba

D77955 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D77955

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Work Shop for Deaf St., Ward 18)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Moses Jaslow

(Residence in Baltimore: No. 826 Sarah Ann St. St. Yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: ..... (Month) ..... (Day) 1870 (Year)

7-AGE: 53 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Shoemaker
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Pa.

PARENTS:

10-NAME OF FATHER: Not known

11-BIRTHPLACE OF FATHER, (State or Country): Not known

12-MAIDEN NAME OF MOTHER: Not known

13-BIRTHPLACE OF MOTHER, (State or Country): Not known

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Easton

(Address) 916 Pa ave

15-

FILED AUG 1 - 1923 ROBERT R. KRAUTER Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 30 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy

(Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Asphyxia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Clinton Radcliffe M. D.

July 31 1923 (Coroner.) (Address) 1436 Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	8-1-, 1923
20-UNDERTAKER.	ADDRESS
David Easton	916 Pa ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77956 D77956

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 923 Druid Hill Ave. Ward)

2-FULL NAME. Estelle - Briscoe

(Residence in Baltimore: No. 923 Druid Hill Ave. ; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1888 (Year)

7-AGE. 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country.) Baltimore

PARENTS.
10-NAME OF FATHER. Estelle Briscoe
11-BIRTHPLACE OF FATHER. (State or Country.) Md
12-MAIDEN NAME OF MOTHER. Sarah Baker
13-BIRTHPLACE OF MOTHER. (State or Country.) Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Sarah Briscoe
(Address) 923 Druid Hill Ave

AUG 1 - 1923 ROBERT R. KRAUTER Burial Permit Clerk
Filed ..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 29 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Gastritis
Error in Diet
(Duration) yrs. 1 mos. 16 hrs.
CONTRIBUTORY (Secondary) Cardiac Asthenia
(Duration) yrs. mos. ds.

(Signed) Geo Edwin Blades M. D.
(Coroner.)
July 29 1923 (Address) 143 N Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	8-1, 1923
20-UNDERTAKER. Daniel Easton	ADDRESS 916 Same

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D77957 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

164 D77957

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1342 Cleveland St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Thomas.

(a) Residence No. 1342 Cleveland St., 21 Ward 21

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Blk

5-SINGLE, MARRIED, WIDOWED, or DIVORCED, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Eliz Thomas

6-DATE OF BIRTH (month, day and year) 1863

7-AGE 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Rock Hall Kent Co

PARENTS

10-NAME OF FATHER, Thomas Thomas

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, McCarron

13-BIRTHPLACE OF MOTHER (city or town) (State or Country)

14-INFORMANT (Informant) B. F. Thomas (Address) 1354 Cleveland St

15-Filed Aug 1 1923 ROBERT R. KRAUTER Burial Permit Issuer.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 29. 23

17-I HEREBY CERTIFY, That I attended deceased from June 1 1923 to July 29 1923

that I last saw him alive on July 29 1923

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Senility

Arteriosclerosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Nov Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Jno V Schwartzbury M. D.

July 30 1923 (Address) 126 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Auburn Cem — DATE OF BURIAL, 8-2- 1923

20-UNDERTAKER, Daniel Easton — ADDRESS 916 Ca ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

165985
D77958

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77958

159-003

CERTIFICATE OF DEATH.

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD) NO

2-FULL NAME Edward Schaub.

(a) RESIDENCE NO. 51 S. 11th St. City ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a (If married, widowed, or divorced) HUSBAND of (or) WIFE of: Francis Schaub. (father).

6 DATE OF BIRTH (month, day, and year): July 27, 1923

7 AGE — Years — Months — Days: 4. If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland.

PARENTS

10 NAME OF FATHER: Francis Schaub.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Anna Markert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Record JOHNS HOPKINS HOSPITAL

15 AUG 1 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1923, to July 31, 1923.

That I last saw him alive on July 31, 1923,

and that death occurred, on the date stated above, at 12.5 P. m.

The CAUSE OF DEATH* was as follows:

Imperforate Anus

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of 7/29/23.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosemer

DATE OF BURIAL: Aug 1923

20 UNDERTAKER: Kendall Dyer & Son

ADDRESS: 3781 —

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

91-002 D77959

D77959

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1012 S. Sharp ST., WARD 17

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hettche

(a) RESIDENCE NO. 1012 S. Sharp ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Hettche

6 DATE OF BIRTH (month, day, and year): Jan 20 1844

7 AGE — Years: 79 Months: 7 Days: 9 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Truckman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Hettche

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Elizabeth Hettche (Address) 1012 S. Sharp St

15 Filed AUG 1 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 29 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923 to July 29, 1923

that I last saw him alive on July 29, 1923

and that death occurred, on the date stated above, at 10:10 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthenia

CONTRIBUTORY (Secondary) Sen Art Sclerosis (duration) yrs. 6 mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopay?

What test confirmed diagnosis?

(Signed) John A. Schwemsberger M. D.

19 (Address) 1176 W Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem — DATE OF BURIAL: Aug 2 1923

20 UNDERTAKER: Philip Herring — ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

S. A. FETTY

Spec.—1-10-21—M&T—1500 Bks.

D77960

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-101

D77960

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Stonington Ave ST., Howard Park WARD) N

2-FULL NAME Amanda Elizabeth Reese

(a) RESIDENCE NO. Stonington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Lee Reese

6 DATE OF BIRTH (month, day, and year): Mar 24 1848

7 AGE — Years: 75 — Months: 4 — Days: 7 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: Geo. W. Keiser

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Maria Quigley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Mrs. Wm. F. Rogers

(Address) Stonington Ave

15 Filed AUG 1 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 1 1923

17

I HEREBY CERTIFY, That I attended deceased from not less than 30 years 19 . to July 31. 1923.

that I last saw her alive on July 31st. 1923.

and that death occurred, on the date stated above, at 1:20. a. m.

The CAUSE OF DEATH* was as follows:

Cerebral effusion

(Apoplexy)

about 10 hours (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis, with high B. P. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No. Date of X

Was there an autopsy? Not necessary.

What test confirmed diagnosis? General symptoms

(Signed) Edwin C. Price M. D.

. 19 (Address) 1012 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. — DATE OF BURIAL: Aug 3, 1923

20 UNDERTAKER: Wm. Flickner & Son — ADDRESS: North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77961

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D77961

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 1543 N Patterson Park Ave ST.) (8 WARD)

2-FULL NAME George Henry Douglas

(a) RESIDENCE. No. 2361 E. Federal ST., 8 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., If of foreign birth? 65 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna B Douglas

6 DATE OF BIRTH (month, day, and year) Aug 22 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
65	65	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar-maker

(b) General nature of industry, business, or establishment in which employed (or employer): Cigar mfg

(c) Name of employer: Wm Bouchet & Sons

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Douglas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Tragesser

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Anna B Douglas

(Address) 2361 E Federal St

15 Filed AUG 1 1923 ROBERT A. KRAMER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1923

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1923, to July 30, 1923, that I last saw him alive on July 30, 1923, and that death occurred, on the date stated above, at 6.10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervical gland of Neck

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H J Herzog MD, M. D.

Jul 31, 1923 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug. 2 1923

20 UNDERTAKER: Geo. J. Ruth — ADDRESS: 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77962 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77962

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1302 E. La Fayette Ave. St. 10 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen A. Hennelly

(a) RESIDENCE. No. 1302 E. La Fayette Ave, WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? 66 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late Christopher T. Hennelly

6 DATE OF BIRTH (month, day, and year): Aug. 12 1844

7 AGE: Years 79 | Months 11 | Days 17 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Belfast Ireland

PARENTS

10 NAME OF FATHER: Hermann Hannetty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Belfast Ireland

12 MAIDEN NAME OF MOTHER: Hammel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Belfast Ireland

14 Informant: Mrs Irvin Hannetty

(Address) 1302 E La Fayette Ave.

15 Filed ....., 19.....

AUG 1 1923 ROBERT R. KINSEY Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30 1923.

17 I HEREBY CERTIFY, That I attended deceased from July 4 1923 to July 30 1923, that I last saw h Ex alive on July 30 1923, and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Fracture Neck of Femur

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Louis H. A. Meyer, M. D.

July 31. 1923 (Address) 1031 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Aug 2 1923
20 UNDERTAKER	ADDRESS
Geo. J. Ruth	1735 Harford Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should take CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77963

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77963

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2509 Fleet ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Tomas Stefanski

(a) RESIDENCE NO. 2509 Fleet ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Cecilia Stefanski

6 DATE OF BIRTH (month, day, and year) Dec 10 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Anthony Stefanski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Cecilia Stefanski

(Address) 2509 Fleet St.

15 AUG 1 - 1923 ROBERT R. KRAMER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1923

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1923 to July 31, 1923

that I last saw him alive on July 31, 1923

and that death occurred, on the date stated above, at 12 15 A m.

The CAUSE OF DEATH* was as follows:

Laryngeal Tuberculosis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Kupanek M. D.

(Address) 2332 Baker, 2 Lakewood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	August 3 1923

20 UNDERTAKER John H Weber ADDRESS 1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77964 D77964

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 Wyeth ST., WARD 11

2-FULL NAME John W Tyler

(a) RESIDENCE NO. 622 Wyeth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia Tyler

6 DATE OF BIRTH (month, day, and year) Jan 18 60

7 AGE Years 63 | Months 6 | Days 22 | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) House

(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Geo H. Tyler

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Riggin

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Mrs E. Todd

(Address) 1400 Eutaw St.

15 Date Received AUG 1 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 1923

17 I HEREBY CERTIFY, That I attended deceased from May 30 1923 to July 30 1923

that I last saw h alive on July 30 1923

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

of Stomach

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza 2

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) R. H. Campbell M. D.

July 30 1923 (Address) 1649 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. | DATE OF BURIAL Aug 1 1923

20 UNDERTAKER Joseph B. Cook | ADDRESS 1023 N. Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77965

CERTIFICATE OF DEATH.

3/ D77965

1-PLACE OF DEATH Bon Secours Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Fayette and Payson ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Emma Ogle

(a) RESIDENCE NO. 441 S. Fulton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier in office

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Ogle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bertha Houde

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Jennie L. Ogle

(Address) 441 S. Fulton Ave

15 Filed AUG 1 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29th 1923

17

I HEREBY CERTIFY, That I attended deceased from July 14th, 1923, to July 29th, 1923, that I last saw her alive on July 29th, 1923, and that death occurred, on the date stated above, at 9½ P. m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) yrs. 1 mos 6 ds.

CONTRIBUTORY (Secondary) Pulmonary tubercular

(duration) 2 yrs. + mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Diagnosis

(Signed) H. Moore, M. D.

1923 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	8/2/23

UNDERTAKER Geo. Conley ADDRESS Fulton & Fayette

D77966 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77966

CERTIFICATE OF DEATH.

202

1-PLACE OF DEATH City of BALTIMORE: (No. Mercy Hospital St., Ward) Registered No. C. No

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank A. Burke,

(Residence in Baltimore: No. 3206 E Balto St.; yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Married

6-DATE OF BIRTH: June (Month) 27 (Day) '88 (Year)

7-AGE: 36 yrs. 1 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Fireman
(b) General nature of industry, business, or establishment in which employed (or employer): Engineer

9-BIRTHPLACE, (State or Country): Maryland

PARENTS:

10-NAME OF FATHER: Michael F. Burke

11-BIRTHPLACE OF FATHER, (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Annie C

13-BIRTHPLACE OF MOTHER, (State or Country): Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A. Burke

(Address) 3206 E Balto

15- Filed AUG 1 - 1923 ROBERT R. KRAUTER, Burial Permit Section

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 30 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures
Accident

(Duration) yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Geo C Blades M. D.
(Coroner.)

July 1 - 1923 (Address) 163 N Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Cathedral Cem. DATE OF BURIAL: 8/2/23

20-UNDERTAKER: Geo A Farley ADDRESS Fulton & Lafayette

Spec.—1-10-21—M&T—1500 Bks.

165386

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77967

CERTIFICATE OF DEATH.

X16-002 D77967

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carroll Williams

(a) RESIDENCE NO. Savage, Maryland ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 days How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND~~ of ~~or WIFE of~~ Bertha Williams (mother)

6 DATE OF BIRTH (month, day, and year) Sept. 19, 1921.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Samuel Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Bertha Hebron

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Records, JOHNS HOPKINS HOSPITAL (Address)

15 AUG 1 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1923, to July 31, 1923, that I last saw him alive on July 31, 1923, and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery (Flexner).

(duration) 0 yrs. 0 mos. 9 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Savage Md

DATE OF BURIAL: Aug 1 1923

20 UNDERTAKER: Brand Freland Schroder

ADDRESS 1400

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77968

CERTIFICATE OF DEATH.

16-002 D77968

1-PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith May McCormick

(a) RESIDENCE No. 923 Burgundy ST., WARD Balto. Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 4, 1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Eubert McCormick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Maud Travers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Eubert McCormick

(Address) 923 Burgundy St

15 Filed AUG 1 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1923

17

I HEREBY CERTIFY, That I attended deceased from July 19, 1923, to July 31, 1923, that I last saw him alive on July, 31, 1923, and that death occurred, on the date stated above, at 8:55 P. m.

The CAUSE OF DEATH* was as follows:

Bacillary dysentery

(duration) ... yrs. 1 mos ... ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? at home?

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Bloody mucous in Stools.

(Signed) ABPrice, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL Aug 3 19 22

20 UNDERTAKER John Fields — ADDRESS 1200 W Fayette

D77969

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77969

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 915 So. Caroline St., Ward 1)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ricky Smith

(Residence in Baltimore: No. 915 So. Caroline St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

6-DATE OF BIRTH. About Unknown (Month) (Day) (Year)

7-AGE: 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Germany

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. Smith

(Address) 412 So. Wolf St

15- AUG 1 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 30 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death (Autopsy or Inquiry.) on the day stated above.

The CAUSE OF DEATH was as follows:

Apoplexy

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. P. Lawton M. D.

(Coroner) July 31st 1923 (Address) Curtis Bay Balto. Md

State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means of Injury; and whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Trinity Cem. DATE OF BURIAL, 8/2/23 19

UNDERTAKER, Frederick W. Zozenske ADDRESS 1930 Eastern Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D77970

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77970

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH Christs Institution Hospital

CITY OF BALTIMORE: (No. 704 Ensor St ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maria Boone

(a) RESIDENCE NO. 1518 Jefferson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fml

4 COLOR OR RACE C.

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Boone

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE 52 Years — Months — Days — If LESS than 1 day, hrs. or min.

52.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs. R. C. Elliott 1725 Eastland Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1 1923 to July 31 1923

that I last saw her alive on July 31, 1923

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Paralysis + Complications

Disease (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Paralysis + Complica

tions Disease (duration) yrs. 7 mos. 10 ds.

18 Where was disease contracted if not at place of death? 1518 Jefferson St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D. Gill Kennard M. D.

7-31. 1923 (Address) 708 Ensor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL-CREMATION OR REMOVAL — DATE OF BURIAL

Mayotty A. A. Co. Md. Aug 5 1923

20 UNDERTAKER — ADDRESS

Mrs. R. C. Elliott 1725 Eastland

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77971

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77971

CERTIFICATE OF DEATH C-1,095,186

1-PLACE OF DEATH U.S. Veterans' Hospital No. 56 Ft. McHenry, Md.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME William H. DUCKETT

(a) RESIDENCE NO. 304 Sumner Road, S. E. Washington, D. C. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) ----

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) D. C.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country) unknown

14 Informant Hospital Records, (Address) Ft. McHenry, Md.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 23, 1922 to Aug. 1, 1923, that I last saw him alive on Aug. 1, 1923, and that death occurred, on the date stated above, at 5:00 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosus Meningitis

(duration) ..... yrs. ..... mos 10 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 2 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of ----

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) H. W. Barker, Surgeon (R) M. D.

Aug. 1 1923 (Address) Ft. McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D. C.	8/1 1923
20 UNDERTAKER	ADDRESS
S. Levinson & Bro	1127 E Balto st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77972 ✓ D77972

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 Willow Ave Gwynn ST., WARD 17

2-FULL NAME Emma Irene Ball

(a) RESIDENCE NO. 511 Willow Ave Gwynn ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of George W. Ball

6 DATE OF BIRTH (month, day, and year) May 14th 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fort Worth Texas

PARENTS
10 NAME OF FATHER Benjamin Hinkley
11 BIRTHPLACE OF FATHER (city or town) (State or country) Portland Maine
12 MAIDEN NAME OF MOTHER Kate Servey
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Rome. N. Y.

14 Informant George W. Ball
(Address) 511 Willow Ave Gwynn

15 Aug 1923 ....., 19..... Robert P. Perrison. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 19 23

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1923, to July 31, 1923,
that I last saw her alive on July 31, 1923,
and that death occurred, on the date stated above, at 6 P. m.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
Chronic Myocarditis

(duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Toxaemia
(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? Same
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) E. W. Bayley, M. D.
Aug 1, 1923 (Address) 501 Sheridan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 2nd 1923
20 UNDERTAKER	ADDRESS
Leo. G. Cook	Northern Parkway

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77973

CERTIFICATE OF DEATH.

118-002

D77973

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home and Infirmary St., WARD)

2-FULL NAME Capt Edwin Clark.

(a) RESIDENCE No. Roswell, New Mexico ST., WARD Roswell, New Mexico

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. / mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 [illegible] or Divorced, (write the word)
male	white	divorced

5a If married, widowed, or divorced HUSBAND of [illegible] Marion O'Conner

6 DATE OF BIRTH (month, day, and year) Mch. 11. 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain U.S.Army

(b) General nature of Industry, business, or establishment in which employed (or employer) Military

(c) Name of employer U.S.Government

9 BIRTHPLACE (city or town) Roswell

(State or country) New Mexico

PARENTS

10 NAME OF FATHER Dillard Hazelrigg Clark

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Ella DeLany

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Iowa

14 Informant Dillard H.Clark

(Address) New Mexico

15 - 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29 1923

17

I HEREBY CERTIFY, That I attended deceased from June 22nd, 1923, to July 29th, 1923, that I last saw h[illegible] alive on July 29th, 1923, and that death occurred, on the date stated above, at 10.10 p.m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia Peritonitis Ch

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 22nd, 23

Was there an autopsy? Yes Autopsy Findings

What test confirmed diagnosis?

(Signed) Richard S. Clark, M. D.

. 19 (Address) Church Home & Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arlington, Washington D.C.	8-2-23 19
20 UNDERTAKER	ADDRESS
H.E.Hughes	424 N.Broadway

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION may be very important. See Instructions on back of certificates.

661

Spec.—1-10-21—M&T—1500 Bks.

D77974 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D77974

D77974 CERTIFICATE OF DEATH. 143-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Gen Hospt. ST., WARD 10

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Helen Shimkivich Helen Shimkivych

(a) RESIDENCE NO. 1506 W Fayette St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 17 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE 38 Years — Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) -- -

(c) Name of employer - -

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER Alx. Dovidatis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Anna Zuravckas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant Veronika Zulene
(Address) 1510 W Fayette Street

15 Filed AUG 2 - 1923 ROBERT A. KRAETER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-31-23

17 I HEREBY CERTIFY, That I attended deceased from 7-22-23, 19 ... to 7-31-23, 19 ..., that I last saw h[illegible] alive on 7-31-23, 19 ..., and that death occurred, on the date stated above, at 10 20 p m.

The CAUSE OF DEATH* was as follows:

Eclampsia pregnancy

(duration) yrs. 4 mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of 7-24-23

Was there an autopsy? None

What test confirmed diagnosis? Cynical Laboratory findings

(Signed) [illegible] No Autopsy M. D.

, 19 (Address) Md Gen Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Aug. 4. 1923

20 UNDERTAKER: John Grebliauckas — ADDRESS: 425 S Paca St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77975

CERTIFICATE OF DEATH.

160

D77975

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 816 Woodley ST., (WARD) 10

2-FULL NAME Julia Edith Birch

(a) RESIDENCE No. 816 Woodley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Wht	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 29/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Edw. Birch

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Marie Broom

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Mrs Marie Birch

(Address) 816 Woodley St

15 Filed AUG 2 - 1923, 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1st 1923

17

I HEREBY CERTIFY, That I attended deceased from July 29th 23, 19 to Aug 1st 23, 19.

that I last saw her alive on Aug 1st, 19 23.

and that death occurred, on the date stated above, at 10 20 a.m.

The CAUSE OF DEATH* was as follows:

Jaundice of the newborn

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Marasmus & Inanition due to

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no Visible

What test confirmed diagnosis?

(Signed) [illegible] M. D.

8/1, 19 23 (Address) 1605 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Aug 2 1923
20 UNDERTAKER	**ADDRESS**
Wm J Kuerthes	North Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77976 D77976

CERTIFICATE OF DEATH.

X 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen'l. Hospital St., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howell Downing Bayley

(a) RESIDENCE NO. Md. Genl Hosp. ST., 11 WARD Henford. Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 11 ds. How long in U. S., if of foreign birth? 59 yrs. 0 mos. 1 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Slair Bayley

6 DATE OF BIRTH (month, day, and year) July-29-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore, (State or country) Maryland.

PARENTS

10 NAME OF FATHER Robert P. Bayley

11 BIRTHPLACE OF FATHER (city or town) Cork, (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Emma L Downing

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Emma L. Bayley-(mother) (Address) 924 W North Ave

15 AUG 2 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1923, to July 30, 1923, that I last saw him alive on July 30, 1923, and that death occurred, on the date stated above, at 11 15 P. m.

The CAUSE OF DEATH* was as follows:

(Auricular Fibrillation) → had this since Dec 1921.

Myocarditis.

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema, Ascites (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs and symptoms

(Signed) Tho A Tompkins, M. D.

, 19 (Address) Maryland Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	Aug 2 1923
20 UNDERTAKER STEWART & MOWEN CO. (WILLIAM F. WOODEN, [redacted])	ADDRESS 108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D77977 — 90 D77977

1-PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. U.S.Guano Co. Curtis Bay St., WARD) 14

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Charles H.Smith.(C)

(a) RESIDENCE No. 2010 Etting St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Married.

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of XXXXXXXXX Mary Smith,(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: U.S.Guano Co.

9 BIRTHPLACE (city or town) (State or country): Virginia.

PARENTS

10 NAME OF FATHER: William B.Smith.(C)

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia.

12 MAIDEN NAME OF MOTHER: Sallie Harkum.(C)

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia.

14 Informant: Mary Smith.(C) wife. (Address): 2010 Etting St.

15 Filed AUG 2 - 1923 ROBERT R. CRAUTON Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 30th. 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained hy said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto Reinhardt M. D.
(Coroner)

7/31 . 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Aug 2 1923

20 UNDERTAKER: Samuel J. Hensley — ADDRESS: [illegible]

CAUSE OF DEATH should be clearly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77978

CERTIFICATE OF DEATH.

D77978

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal tuberculosis Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Moore

(a) Residence No. 528 Gold st. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Singl

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1902

7-AGE.	If LESS than 1 day.
21 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Actress

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9-BIRTHPLACE (city or town) (State or Country): Kentucky

PARENTS:

10-NAME OF FATHER: James Moore

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Kentucky

12-MAIDEN NAME OF MOTHER: Mary Ellen Scott

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Kentucky

11- (Informant): Hospital Records

(Address): M.T.H.

15- AUG 2 - 1923 ROBERT R. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): July 30, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 21 19 23 to July 30 19 23

that I last saw her alive on July 30 19 23

and that death occurred, on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 5 mos. ds

CONTRIBUTORY (Secondary) Spontaneous pneumothorax Right Sided

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? T.B. in sputum, X-ray

7-30-23 (Signed) L. A. Lally M. D.

19 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible] DATE OF BURIAL: [illegible] 19 23

20-UNDERTAKER: Edmund L. Stanley ADDRESS [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77979

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 D77979

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 805 Whitelock St ST., WARD 13

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Israel Rubenstein

(a) RESIDENCE NO. 805 Whitelock St ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? 33 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leah Rubenstein

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Leah Rubenstein (Address) 805 Whitelock St

15 Filed AUG 2 19 1923 ROBERT R. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1923

17

I HEREBY CERTIFY, That I attended deceased from Oct 20, 1922, to July 28, 1923, that I last saw him alive on July 28, 1923, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Degeneration

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein M. D.

8/2, 1923 (Address) 733 Asquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Wm Southern Cem	8/2 1923
20 UNDERTAKER	ADDRESS
Jack Lewis	1437 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary Tuberculosis

Spec.—1-10-21—M&T—1500 Blks.

D77980

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77980

CERTIFICATE OF DEATH.

14-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 949 N Gay Street ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr Samuel Halpern

(a) RESIDENCE NO. 949 N. Gay street ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Helen Halpern

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 65 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dentist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 E Baltimore st

15 Filed AUG 2 1923 ROBERT R. KRAMER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 1 1923

17

I HEREBY CERTIFY, That I attended deceased from June, 1920, to ~~July~~ Aug. 1, 1923, that I last saw h[illegible] alive on Aug. 1, 1923, and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

General arteriosclerosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary): Cerebral thrombosis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. A. Michelson M. D.

, 19 (Address) 2230 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Ass

DATE OF BURIAL: 8/2 1923

20 UNDERTAKER: Jack Lewis 1439 E Balto st

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77981

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D77981

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.; 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stella Posner

(a) RESIDENCE. NO. 2072 Linden Ave ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Samuel Posner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Jennie Sugar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Samuel Posner
(Address) 2072 Linden ave

15 AUG 2 1923 ROBERT R. KRAMER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 1st 1923

17

I HEREBY CERTIFY, That I attended deceased from July 20th, 1923, to Aug. 1st, 1923, that I last saw her alive on Aug. 1st, 1923, and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Aortic & mitral insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Aortic dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. J. Buffin M. D.

8/1/23, 19 (Address) 710 Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	Aug 2 1923

20 UNDERTAKER Jack Lewis 1439 E Baltimore ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other abnormal condition. No rheumatism.

Spec.—1-10-21—M&T—1500 Blks.

D77982

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 49 D77982

REGISTERED NO. 7

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital, ST., 9 WARD)

2-FULL NAME William Facemire.

(a) RESIDENCE NO. Bradon Co, W. Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced (write the word): Widowed.

5a If married, widowed, or divorced ~~HUSBAND (or) of~~ ~~(or) WIFE of~~ John Skidmore (friend).

6 DATE OF BIRTH (month, day, and year) Feb. 7, 1867.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	5	25.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER James Facemire.

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Celia Shonestriff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 2 - 1923 ROBERT R. KRAMER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1923 to Aug 1, 1923.

that I last saw him alive on Aug 1, 1923,

and that death occurred, on the date stated above, at 12 M. P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes Autopsy.

What test confirmed diagnosis?

(Signed) Cleveland Lee M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sutton W Va — DATE OF BURIAL: aug 2 1923

20 UNDERTAKER: Joseph ahrens — ADDRESS: 22 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D77983

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

8/4 D77983

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Schoen

(a) RESIDENCE NO. 1814 N Ruxton ave ST., 15 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced (or) WIFE of HUSBAND of

6 DATE OF BIRTH (month, day, and year) Quekenam

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Louis Schoen

11 BIRTHPLACE OF FATHER (city or town) Prussia
(State or country) Philica

12 MAIDEN NAME OF MOTHER Fannie Morganstern

13 BIRTHPLACE OF MOTHER (city or town) Rebbia
(State or country) Austria

14 Informant Records JOHNS HOPKINS HOSPITAL
(Address)

15 Filed AUG 2 1923 ROBERT R. KRAETZER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1923

17

I HEREBY CERTIFY, That I attended deceased from July 31, 1923, to Aug 1, 1923, that I last saw her alive on August 1, 1923, and that death occurred, on the date stated above, at 3:10 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug 1-1923

Was there an autopsy? No

What test confirmed diagnosis? operation

(Signed) Warfield M. Firor, M. D.

Aug 1, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 8/2 1923

20 UNDERTAKER S. Lennon & Bro

ADDRESS 1127 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tubercular

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77984

CERTIFICATE OF DEATH.

51 D77984

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525 N. Gilmor ST.; WARD) 19

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louisa Young

(Residence in Baltimore: No. 525 N. Gilmor St.; 20 yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Oct 11, 1866 (Month) (Day) (Year)

7-AGE, 56 yrs. 9 mos. 20 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), S C

PARENTS.

10-NAME OF FATHER, John Parker

11-BIRTHPLACE OF FATHER (State or Country), S. C

12-MAIDEN NAME OF MOTHER, Dora Connor

13-BIRTHPLACE OF MOTHER (State or Country), S. C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Virginia Young

(Address) 525 N. Gilmor

15-

AUG 2 1923 ROBERT R. KRAUTER, Clerk

Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 31, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Jan 15 1923, to July 31 1923, that I saw h[illegible] alive on July 30 1923, and that death occurred, on the date stated above, at 4P m.

The CAUSE OF DEATH* was as follows: Acute dilatation of the heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(Duration) 1 yrs. 7 mos. ds.

(Signed) W. T. Coleman M. D.

Aug 1—, 1923 (Address) 1037 McCulloh

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cem. DATE OF BURIAL, Aug 2, 1923

20-UNDERTAKER Sam'l N. Carter Sons ADDRESS 1400 Mosher

Spec.—1-10-21—M&T—1500 Blks.

D77985

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 161-001

D77985

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2563 Frederick Ave ST., WARD 20

2-FULL NAME Caroline Rosie Koslowski

(a) RESIDENCE NO. 2563 Frederick Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. — mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 31-23.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Herman Koslowski

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Anna Seiglinn

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Herman Koslowski
(Address) 2563 Frederick Ave.

15 Filed AUG 2 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 1st 1923

17

I HEREBY CERTIFY, That I attended deceased from July 31 , 1923 , to August 1st , 1923 ,
that I last saw her alive on August 1st , 1923 ,
and that death occurred, on the date stated above, at 9:00 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Chester Rikard, M. D.

8-2-, 1923 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug. 2 1923
20 UNDERTAKER George L. Schwab	ADDRESS 1100 Fulton Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D77986

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D77986

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal tuberculosis Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Scurry

(a) Residence No. 906 Leadenhall st., St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1885 ?

7-AGE. 38? yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Fireman

(b) General nature of industry, business, or establishment in which employed (or employer). Boat

(c) Name of employer. Unknown

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Erin scurry

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Minervia wilson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14-(Informant). Hospital Records

(Address). M. T. H.

15-Filed AUG 2 1923 ROBERT N. KRAUTH. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 1, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to Aug. 1, 1923, that I last saw him alive on Aug. 1, 1923, and that death occurred, on the date stated above, at 6.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(Duration) yrs. 1 mos. 14 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) La Lally, M. D.

8-1-23 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt auburn

DATE OF BURIAL. Aug 3 1923

20-UNDERTAKER. R L Parham

ADDRESS 902 Leadenhall st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D77987

CERTIFICATE OF DEATH.

90

D77987

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1187 East Ave ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha A Rothenburg

(a) RESIDENCE. No. 1187 East Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Rothenburg

6 DATE OF BIRTH (month, day, and year) Feb. 10-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Jno Kessler

11 BIRTHPLACE OF FATHER (city or town) (State or country) German

12 MAIDEN NAME OF MOTHER Engleborn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) German

14 Informant Jno. H. Rothenburg

(Address) 118 N. East Ave

15 Filed AUG 2 - 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31- 1923

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1923, to July 31, 1923, that I last saw her alive on July 30, 1923, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. mos. 6½ ds.

CONTRIBUTORY (Secondary) Bronchial Consumption

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical Exam

(Signed) Geo Esteban Blades, M. D.

(Address) 1437 N Bway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	7/41 1923
20 UNDERTAKER J. A. Inman	ADDRESS 300 E Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77988

CERTIFICATE OF DEATH.

46 D77988

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1506 E. Oliver ST. WARD)

2-FULL NAME Ann L. Montgomery

(a) RESIDENCE No. 1506 E. Oliver ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. P. Montgomery

6 DATE OF BIRTH (month, day, and year): Aug 12-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York City

PARENTS

10 NAME OF FATHER: James Carey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Anna Flemming

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Y.

14 Informant (Address): Wm. P. Montgomery 1506 E. Oliver St.

15 Filed AUG 2 - 1923 ROBERT R. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 31st 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1922 to July 31 1923.

that I last saw her alive on July 30 1923.

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Cervix

(duration) yrs. 17 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Radium Date of

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) F. J. Kirby, M. D.

dated July 1, 1923 (Address) 110 E. Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. DATE OF BURIAL 8/3/1923

20 UNDERTAKER: J. A. Moran ADDRESS 300 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77989 ✓ D77989

CERTIFICATE OF DEATH.

44

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 N Belnord Ave ST., ... WARD)

2-FULL NAME Theresa Blazer

(a) RESIDENCE NO. 216 N Belnord ST., 6 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Blazer

6 DATE OF BIRTH (month, day, and year) June 18. 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Andrew Gratel

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Dora Kurt

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Mrs Margaret Tolerath
(Address) 216 N Belnord Ave

15 AUG 2 - 1923 . 19 ROGER K. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 29 . 19 23 to Aug 1st . 19 23
that I last saw her alive on Aug 1st . 19 23
and that death occurred, on the date stated above, at 6 - a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) C H Meyer Jr M. D.

8/3 1923 (Address) 1638 E Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Aug 4 1923

20 UNDERTAKER John Ulrich

ADDRESS 2008 Aliceanna

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D77990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002 D77990

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1012 Biscoe ST., WARD)

2-FULL NAME George J. Peters Sr.

(a) RESIDENCE NO. 1012 Biscoe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Ellen Peters

6 DATE OF BIRTH (month, day, and year) Nov 9 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	75	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Casper Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Eliz Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Ellen Peters

(Address) 1012 Biscoe St

15 Filed Aug 2 1923 19 ... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2. 1923

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1923, to Aug 2, 1923, that I last saw h[illegible] alive on Aug 1, 1923, and that death occurred, on the date stated above, at 6.15 A m.

The CAUSE OF DEATH* was as follows:

Old age

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Winkler M.D. M. D.

(Address) 1918 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ed Peters Cem.	8-6 1923
20 UNDERTAKER James Dignan & Son	ADDRESS 1000 S. Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Z 4062

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77991

CERTIFICATE OF DEATH.

129 D77991

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1450 Boyle ST., WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis A Colwell (Caldwell)

(a) RESIDENCE NO. 1450 Boyle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a ~~If married~~, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~: Sarah Colwell

6 DATE OF BIRTH (month, day, and year): April 27 1859

7 AGE — Years: 64 — Months: 3 — Days: 5 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Mrs. Chas Rebstock

(Address) 1450 Boyle St

15 Filed AUG 2 1923, 19

ROBERT N. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 1 1923

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1923, to Aug 1, 1923, that I last saw him alive on Aug 1, 1923, and that death occurred, on the date stated above, at 3 30 a m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) ... yrs. ... mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs.

(Signed) Sidney H. Street, M. D.

8/1, 1923 (Address) 405 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: 8-3 1923

20 UNDERTAKER: Ed B Hale — ADDRESS: 115 E West St

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

A K S

D77992

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77992

CERTIFICATE OF DEATH.

X 9/85

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Baum

(Residence in Baltimore: No. 304 Matthews St. (St., 35 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	widower

6-DATE OF BIRTH, ... unknown ....., 1.....
(Month) (Day) (Year)

7-AGE. 74 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Penna R.R.Union
(b) General nature of industry, business, or establishment in which employed (or employer): Tunnel (retired)

9-BIRTHPLACE, (State or Country). Penna

PARENTS:

10-NAME OF FATHER, John Baum

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Catherine (uhknown

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter H.Baum (son)

(Address) York,Pa.

15- AUG 2 1923 Robert P. harrison, 192..... Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 1st, 23, 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractured Skull- Accidental, fell down stairs.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S H Bates M. D.
(Coroner.)

8/2/23 192.... (Address) 506 E. North Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
York Pa.	Aug 2, 1923
20-UNDERTAKER.	ADDRESS
Richard H Conley	1108 Guilford Ave

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D77993

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77993

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 Ravenswood ST., WARD)

2-FULL NAME Olive A. Gude

(a) RESIDENCE NO. 522 Ravenswood Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Arnold J. Gude

6 DATE OF BIRTH (month, day, and year) Sept 8 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	52	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Captain Andrew Wyatt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Emily M Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Arnold J. Gude

(Address) 522 Ravenswood Av

15 Filed AUG 2 1923 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from January 2, 1920 to July 1, 1923, that I last saw h~~er~~ alive on July 30, 1923, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Interstitial Nephritis

Chronic Myocarditis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 1 mos. 17 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? — Clinical findings

(Signed) E. R. Bishop M. D.

(Address) 501 Shirley Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park.

DATE OF BURIAL Aug 3 1923

20 UNDERTAKER W. M. Cook

ADDRESS 502 E Hamilton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77994

CERTIFICATE OF DEATH.

44 D77994

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 Race Street ST.; 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Theresa M. Ernst

(Residence in Baltimore: No. 1611 Race Street St.; 42 yrs., ... mos. ..... ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, January (Month) 29 (Day), 1859 (Year)

7-AGE, 64 yrs. 6 mos. 2 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Joseph Maurice

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Theresa (Unknown)

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Jakin Ernst

(Address) 1611 Race Street

15-

Filed ..... 191.....

AUG 2 - 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 31 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1922, to July 31 1923, that I saw her alive on July 30 1923, and that death occurred, on the date stated above, at 6.20 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pelvic and Abdominal Organs

Duration: 9 yrs. 10 mos. ..... ds.

CONTRIBUTORY (Secondary) Carcinoma of Pelvic and abdominal Organs

~~Duration~~ 9 yrs. 10 mos. ..... ds.

(Signed) Frances A. Carpenter M. D.

July 31, 1923 (Address) 2101 Madison Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL,	DATE OF BURIAL.
Cedar Hill Cem	Aug 3., 1923
20-UNDERTAKER Margaret A. Flynn	ADDRESS 1422 Light St.

Spec– 12-23-21—E.B.R.S.—400 Bks.

D77995 HEALTH DEPARTMENT—CITY OF BALTIMORE D77995

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St., 26 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Matson

(a) Residence No. Unknown St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1871

7-AGE, 51 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, ?

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

11- (Informant) Municipal Hospital Records

(Address) UNIVERSITY OF MARYLAND.

13- Filed 1923 19.. Robert F. Harrison Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 31, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 19 1923 to July 31 1923

that I last saw him alive on July 30 1923

and that death occurred, on the date stated above, at 9:25 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Auricular fibrillation

(Duration) 2 (estimated) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure (Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Claude A. Pruce, M. D.

7-31 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND. DATE OF BURIAL, 19..

20-UNDERTAKER, Commissioner Health. ADDRESS AUG 2- 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

259

Spec.—6-9-19—H. P. Co.—1000 Bks.

D77996

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~12446~~ D77996

CERTIFICATE OF DEATH 161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 323 E North Ave ST.. WARD

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hogan

(a) RESIDENCE. No. 3232 North Ave ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: f.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years — Months — Days — If LESS than 1 day: hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balti- md

PARENTS

10 NAME OF FATHER: Richard Hogan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balti md

12 MAIDEN NAME OF MOTHER: Pines

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balti md

14 Informant (Address): Richard Hogan 3232 North Ave

15 Filed AUG 2 - 1923, 19... Robert F. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug-1, 1923 to Aug 1, 1923

that I last saw h alive on Aug 1, 1923.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Premature birth 6 mos. gestation.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ...

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. C. Bruntack M. D.

01-19 (Address) 5318 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19...

20 UNDERTAKER: Commissioner of Health. — ADDRESS AUG 2 - 1923

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REGISTERED FOR BURIAL

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77997

CERTIFICATE OF DEATH.

D77997

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Tedus

(a) RESIDENCE NO. 1724 N. Charles ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1921 Mar 19

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Tedus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Maria Markatony

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Father (Address) 1724 N. Charles St

15 Filed AUG 3 1923 Robt J. Morrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2 1923

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1923, to Aug. 2, 1923, that I last saw her alive on Aug. 2, 1923, and that death occurred, on the date stated above, at 3:10 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

Planning with effusion

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Anaemia (secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Signs & symp.

(Signed) F A Rothfuss, M. D.

, 19 (Address) Uni Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: WOODLAWN CEM — DATE OF BURIAL: AUG 3 1923

20 UNDERTAKER: ROBT. BROOKS & SON — ADDRESS: C C R CALHOUN HOLLINS ST

New added
Lunch Room

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Measles reported in May in Communicable Disease Division.

D77998

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77998

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 701 Roland ave. St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nena Mae Frush

(Residence in Baltimore: No. 701 Roland ave St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Widow

6-DATE OF BIRTH: May 1 (Month) (Day) 1874 (Year)

7-AGE: 49 yrs. 3 mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: R. F. Green

11-BIRTHPLACE OF FATHER, (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Sarah R. Frush

13-BIRTHPLACE OF MOTHER, (State or Country): Balto co Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. G. Frush

(Address) 701 Roland ave

15-

Filed ..... 192.....

Robert P. Harrison

Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Aug 1 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tabular Descurrent of Liver.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Morrissey M. D.
(Coroner.)

(Address) 3632 Roland ave

*State the Disease Causing Death, or, in deaths from Violent Causes, State (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: London Park Cemetery DATE OF BURIAL: Aug 3 1923

20-UNDERTAKER: STEWART & MOWEN COMPANY ADDRESS [redacted]

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D77999

HEALTH DEPARTMENT—CITY OF BALTIMORE

D77999

CERTIFICATE OF DEATH. X 131

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hospital for the Women of Maryland ST., WARD 14

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. May Baetjer

(a) RESIDENCE NO. 317 Fairmont Ave, ST., WARD Winchester, Va.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. George Baetjer

6 DATE OF BIRTH (month, day, and year) Jan 19, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Adam Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Katherine Clinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Hospital Record

(Address)

15 Filed 1923 Albert P. Morton, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1923

17

I HEREBY CERTIFY, That I attended deceased from July 7, 1923, to Aug. 2, 1923, that I last saw her alive on Aug 2, 1923, and that death occurred, on the date stated above, at 12 05 P m.

The CAUSE OF DEATH* was as follows:

Multiple abscesses of the kidney

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) E. T. Goff M. D.

, 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Winchester Va — DATE OF BURIAL Aug 3rd 1923

20 UNDERTAKER Henry W. Jenkins Sons Co — ADDRESS McGuire & Orchard

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

2062

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78000 D78000

CERTIFICATE OF DEATH.

181-001

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1536 Clarkson St. ST., ... WARD) 13

2-FULL NAME John Nicholas Wicklein

(a) RESIDENCE NO. 1536 Clarkson St. ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. 11 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lula E. Wicklein

6 DATE OF BIRTH (month, day, and year) Aug. 6 1881

7 AGE.	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George R. Wicklein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susan E. Hiss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Lula Wicklein
(Address) 1536 Clarkson St.

15 Filed ..... 19 ..... Registrar

AUG 2 - 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 ; 2 1923 19

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1923, to Aug 2, 1923,

that I last saw h alive on Aug 2, 1923

and that death occurred, on the date stated above, at 8 A.M. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R. L. Hampson M. D.

Aug 2 1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 8/4 1923

20 UNDERTAKER J. F. McCully

ADDRESS 130 E Fort

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78001 CERTIFICATE OF DEATH 100-001 D78001

1-PLACE OF DEATH Boyer's Hospital REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (N.) ST., WARD 14

2-FULL NAME Chas. J. Simms

(a) RESIDENCE NO. 430 Simms ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Rachel Simms

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland Baltimore

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do

14 Informant (Address) Boyer's Hospital

15 AUG 3 - 1923 Actg. Registrar Buried Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1. 1923

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1923 to Aug 1. 1923

that I last saw him alive on Aug 1. 1923

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Tuberculosis)

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Acute Mania, Myocarditis

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Jail

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

Signed Jordan N. Goldsmith M. D.

8/2/1923 (Address) Boyer's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ft. Auburn Cemetery

DATE OF BURIAL 8-4 1923

20 UNDERTAKER George T. A. Gibson

ADDRESS 513 Fawn

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78002

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D78002

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Helen Hospital ST.: (WARD) 3

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Hertz Nachlas

(a) RESIDENCE. NO. 2312 Eutaw Place ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 32 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Nachlas

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) General

(c) Name of employer Mdse

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Dr. M. Nachlas

(Address) 2312 Eutaw Place

15 AUG 3 - 1923 ROBERT R. KRAMER, Registrar

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2, 1923

17

I HEREBY CERTIFY, That I attended deceased from July 20 . 1923 . to August 2 . 1923.

that I last saw h in alive on August 2 . 1923.

and that death occurred, on the date stated above, at 12.10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Shapiro M. D

. 19 (Address) 200 N Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	8/3 1923

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Baltimore St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78003

M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

80 D78003

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2103 Westwood Ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernice Zimmerman

(a) RESIDENCE NO. 2103 Westwood Ave (ST., WARD 11)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 26-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Abraham Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Rebecca Feinberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Abraham Zimmerman

(Address) 2103 Westwood ave

15 AUG 3 - 1923 ROBERT R. KRAMER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Birth, 1921, to Aug 2 -, 1923, that I last saw h alive on Aug 2, 1923, and that death occurred, on the date stated above, at 4.50 P m.

The CAUSE OF DEATH* was as follows:

Chronic - Cerebral - Convulsions

Due to Cerebral Hemorrhage

following Malaria (duration) yrs. 1 mos 10 ds

CONTRIBUTORY (Secondary) Bronchitis, Sub acute

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) [illegible] M. D.

, 19 (Address) 125 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 8/3 1923

20 UNDERTAKER Jack Lewis 1439 — ADDRESS E Balto

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78004

CERTIFICATE OF DEATH.

161-001 D78004

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1324 N. Washington St., (WARD) 9

2-FULL NAME Edna Harrison

(a) RESIDENCE NO. 1324 N. Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. 5 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 25 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Margaret Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mr. John Harrison 1324 N. Washington St

15 Filed AUG 3 - 1923 ROBERT R. KRAUTER Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2nd 1923

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1923, to Aug. 2, 1923, that I last saw h[illegible] alive on Aug 2, 1923, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Insanitis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Arteria

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? William F Gruber

(Signed) M. D.

Aug 2nd, 1923 (Address) 1401 N. Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Aug 3rd 1923
20 UNDERTAKER	ADDRESS
Henry Hoeck Son	130 E Eager St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Duration due to Premature Birth.

Spec.—1-10-21—M&T—1500 Blks.

D78005

HEALTH DEPARTMENT—CITY OF BALTIMORE.

48 D78005

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Elsey

(a) RESIDENCE NO. 234 N Durham St Bay View Hospital. ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Diamond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER May Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Municipal Hospital Records.

(Address)

15 Filed ....19.... HUBERT A. KRAUTER, Registrar

4063-1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 1 19 23

17

I HEREBY CERTIFY, That I attended deceased from December 22 1922, to August 1. 1923.

that I last saw her alive on July 31 . 1923,

and that death occurred, on the date stated above, at 6:15 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of nose

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Chas G. Mure M. D.

8-2-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bury Cemetery	Aug 5 1923
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78006

CERTIFICATE OF DEATH.

90 V D78006

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 Whitecourt ST.; WARD) 16

2-FULL NAME Missouri Fletcher

(Residence in Baltimore: No. 1218 Whitecourt St.; 1 yrs., mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH. May 22 (Month) (Day), 1864 (Year)

7-AGE. 59 yrs. 2 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Alabama

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Horace Fletcher

(Address) 1218 Whitecourt Ave

15-

AUG 3 - 1923 ROBERT N. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 2 (Month) (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1923, to Aug 2 1923, that I saw h[illegible] alive on Aug 1 1923, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) T. E. Daughtry M. D.

8-2, 1923 (Address) 1642 Pennsylvania Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn — DATE OF BURIAL, Aug 5, 1923

20-UNDERTAKER Sam'l N. Carey Co — ADDRESS 1400 Mosher

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D. 78007 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 78007

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1534 Boyle st., 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louisa. w. Raabe

(a) RESIDENCE NO. 1534 Boyle st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 4 mos. ds. How long in U. S., if of foreign birth? 63 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or ~~Divorced~~ (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of Frederick Raabe dec'd

6 DATE OF BIRTH (month, day, and year) Feb 21 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Karl Gottschalk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret A. Belt

(Address) 1534 Boyle st

15 Robert F. Garrison, Registrar

AUG 3 - 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 1923 to Aug 3 1923, that I last saw her alive on Aug 3 1923, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of intestines

(duration) yrs. 4 mos bowels ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? signs & symptoms

(Signed) Walter A Coe, M. D.

8/4 1923 (Address) 571 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 6 1923

20 UNDERTAKER Jos Joerden & Son ADDRESS 2178 Pac

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78008

CERTIFICATE OF DEATH.

100-001 D78008

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., WARD 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Regan

(a) RESIDENCE NO. Bay View Hospital. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about 85.?				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 AUG 3 - 1923 JOSEPH S. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1923 to August 1, 1923.

that I last saw her alive on July 31, 1923,

and that death occurred, on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (Terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude G. Dorsey M. D.

8-2-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Patrick Cemetery	Aug 4 1923
20 UNDERTAKER Robt. Tehmer	ADDRESS 1 N. Roxy

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78009

CERTIFICATE OF DEATH.

D78009

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1741 W North Ave. STR. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Gaston Hooper

(a) RESIDENCE. No. 1741 W North Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Josephine Hooper

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Burner

(b) General nature of industry, business, or establishment in which employed (or employer) Retired Cadet

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER John Hooper

11 BIRTHPLACE OF FATHER (City or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Compte

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Md

Informant Mrs J. P. Hooper
(Address) 1741 W North Ave

15 Filed . 19 Registrar

AUG 3 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1923

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1923, to Aug 1, 1923, that I last saw h[illegible] alive on July 29, 1923, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Organic Disease Heart

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema Legs

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James L. Hooper, M. D.

22 . 1923 (Address) 3467 - 28 Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Aug 3 1923

20 UNDERTAKER Martin Lucky Son, ADDRESS 1827 N Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78010 ✓ 1923 50

D78010 873.

CERTIFICATE OF DEATH. 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1334 N Carey ST., WARD)

2-FULL NAME Mary Bias

(a) RESIDENCE NO. 1334 N Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo Bias

6 DATE OF BIRTH (month, day, and year) July 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Arthur Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Julia Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mary Cooper (Address) 1334 N Carey St

15 AUG 3 - 1923 ROBERT T. KRAMER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1 1923

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1923, to Aug 1, 1923.

that I last saw h-e alive on Aug 1, 1923.

and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 3 Weeks

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm K Barton M. D.

. 19 (Address) 1618 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL Aug 5th 1923

20 UNDERTAKER Harman & Wright

ADDRESS 1340 Carey

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78011 | **CERTIFICATE OF DEATH.** | 45 D78011

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 1905 Druid Hill Ave ST.; ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaiah Wesley

(Residence in Baltimore: No. 1905 Druid Hill Ave St.: ..... yrs., ... mos. ..... da.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: Colord

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH: ..... (Month) ..... (Day) ....., 1871 (Year)

7-AGE: 52 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Waiter
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Mack Wesley

11-BIRTHPLACE OF FATHER (State or Country): va

12-MAIDEN NAME OF MOTHER: Nancy Jones Nancy Fleck

13-BIRTHPLACE OF MOTHER (State or Country): va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ella Ma Kelley

(Address) 1905 Druid Hill ave

15-

Filed AUG 3 1923, 191.....

ROBERT N. KRAUTER, Burial Permit [redacted]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: July (Month) 31 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 2 1923, to July 31 1923, that I saw h his alive on July 31 1923, and that death occurred, on the date stated above, at 9 30 p. m.

The CAUSE OF DEATH* was as follows:

Pertoneal Carcinomata

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. D. Mc Carter M. D.

Aug 2, 1923 (Address) 2000 Druid Hill Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery — DATE OF BURIAL, August 3, 1923.

20-UNDERTAKER John H Faddis — ADDRESS 142 N Pine St

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78012

D78012

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 507 W. Lee St., Ward 17)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Fannie E Carter

(a) Residence No.... 507 W Lee St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Dec 3-1910

7-AGE, 12 yrs. 7 mos. 28 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Wm D Carter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Estella Roberts

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14-
(Informant) Estella Carter
(Address) 507 W Lee St

15-
Filed AUG 3 - 1923, 19.. ROBERT A. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug 1-1923

17- I HEREBY CERTIFY, That I attended deceased from April 18, 1923, to Aug 1, 1923, that I last saw h[illegible] alive on July 31, 1923, and that death occurred, on the date stated above, at 8 3/4 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Asthenia

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) A R Fletcher M. D.

Aug 2 1923 (Address) 712 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL, Aug 3, 1923

20-UNDERTAKER: John H Snoden — ADDRESS 142 W Hill St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D78013

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D78013

CERTIFICATE OF DEATH.

196

1-PLACE OF DEATH The Balto. Car & Foundry Co.

REGISTERED NO.

CITY OF BALTIMORE: (No. Curtis Bay. ST., WARD 15

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Steve Ladowski.

(a) RESIDENCE NO. 1629 Pennington Ave. Curtis Bay. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Steel fitter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Balto. Car & Foundry Co

9 BIRTHPLACE (city or town) (State or country) Servia.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Steve Yeltich (Address) 1629 Penhington Ave.

15 Filed AUG 3 1923 ROBERT E. KRAUTER, Burial Permit Recorder

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 1, 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry & autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) & autopsy find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Electrocution.
Accidentally coming in contact with electric rivet heater.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos ds.

(Signed) Otto M. Eisenhardt, M. D. (Coroner.)

Aug. 2, 1923 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A A Co — DATE OF BURIAL Aug 3 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78014

D78014

CERTIFICATE OF DEATH.

9

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2027 Bank ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. McManus

(a) RESIDENCE NO. 2027 Bank ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1st 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Martin J. McManus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catharine L. Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Martin J. McManus (Address) 2027 Bank St

15 Filed AUG 3 - 1923 ROBERT A. KRAMER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1923, to Aug. 1, 1923, that I last saw her alive on Aug 1, 1923, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Edema of Lungs (duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Orville Pleasants M. D.

8/6 1923 (Address) 2402 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Aug 3rd 1923

20 UNDERTAKER Lilly & Guiler

ADDRESS 403 N. Howard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

Settle. 2433-Md Co

D78015

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 31 D78015

REGISTERED NO. ....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2616 Greenmount Ave St.. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hannah Irene Hansen

(a) RESIDENCE NO. 2616 Greenmount Ave ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Adolph

6 DATE OF BIRTH (month, day, and year) July 17 84

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of Industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Geo. W Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Alice Doyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm A. Hansen

(Address) 2616 Greenmount Ave

15 AUG 3 - 1923 ROBERT R. KRAMER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1923

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1923, to August 2, 1923, that I last saw her alive on August 1, 1923, and that death occurred, on the date stated above, at 11-30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? C

(Signed) George W Style M. D.

8/2, 1923 (Address) 1732 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sandy Mount Cem	8-1923
20 UNDERTAKER Wm Cook	ADDRESS 502 E Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78016

CERTIFICATE OF DEATH.

D78016

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1907 Aliceanna (Ward)

(If death occurred in a hospital or institution, give NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Charles Ford

(Residence in Baltimore: No. 1907 Aliceanna St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Unknown

6-DATE OF BIRTH. Unknown
(Month) (Day) (Year)

7-AGE. 50 about yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Sailor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Unknown

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

AUG 3 1923

Filed ..... 192.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 27 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, Autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation Heart

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

(Signed) Jno. B. Norton M. D.

July 31 1923 (Coroner.) (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Trinity Cemetery

DATE OF BURIAL. August 3 1923

20-UNDERTAKER. Geo. F. Rost

ADDRESS 1735 Harford Ave.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78017

CERTIFICATE OF DEATH.

1/4-091

D78017

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2501 Guilford Ave ST., WARD 7

2-FULL NAME Mary C. Moller,

(a) RESIDENCE NO. 2501 Guilford Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Moller

6 DATE OF BIRTH (month, day, and year) Dec. 21 - 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Kaiser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna C.M. Stoeckert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis Moller

(Address) 111 Right St

15 Date AUG 3 - 1923 ROBERT E. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2nd 1923

17

I HEREBY CERTIFY, That I attended deceased from July 30, 1923, to Aug. 2nd, 1923, that I last saw her alive on August 2nd, 1923, and that death occurred, on the date stated above, at 11:10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) D.E. Buxton, M. D.

8 3, 1923 (Address) 301 East Eager.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	8/4 1923
20 UNDERTAKER	ADDRESS
H. G. Tuban & Sons Co.	North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78018

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 30 Eaton St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Evelyn Pongee

(Residence in Baltimore: No. 30 Eaton St.; yrs., mos., ds.) no

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, March (Month) 27 (Day) 1923 (Year)

7-AGE, 15 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Factory Work
(b) General nature of industry, business, or establishment in which employed (or employer): Wilkens Hair Factory

9-BIRTHPLACE, (State or Country): Baltimore, Md.

PARENTS.

10-NAME OF FATHER, John H. Pongee

11-BIRTHPLACE OF FATHER, (State or Country), Prince George Co., Maryland

12-MAIDEN NAME OF MOTHER, Mary Gray

13-BIRTHPLACE OF MOTHER, (State or Country), Baltimore, Maryland.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mary Gay Pongee

(Address) 30 Eaton Ave

15- Robert P. Harrison,

Filed ..... 192.....

G3-1923 Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 1 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner.) M. D.

1923 (Address)

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Western Star Cemetery	Aug. 4,
20-UNDERTAKER.	ADDRESS 32
Mrs. Katie R. Williams	Schroeder

ery item of information state CAUSE OF DEATH in plain terms, so that is very important. See instructions on back of certificate.

Frederick Stewart

D78019

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78019

CERTIFICATE OF DEATH. X 182

1-PLACE OF DEATH

City of BALTIMORE: (No. 0 Ave Fair field St., ... Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. ~~John~~ Frederick Stewart

(Residence in Baltimore: No. S. S. Eagle St.; yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Unknown

6-DATE OF BIRTH. Unknown, 1..... (Month) (Day) (Year)

7-AGE. 22 yrs. — mos. — ds. If LESS than 1 day ....hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Seaman
(b) General nature of industry, business, or establishment in which employed (or employer). U.S. Eagle

9-BIRTHPLACE. (State or Country). Scotland

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER. (State or Country) Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lt. U.S. Captain

(Address) Fairfield Md

15- Robert F. Harrison,

1923 ..... 192.... Registrar.

(Special Permit Clerk.)

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug 2 (Month) (Day) 192-3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning

(Duration) About yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. L. Wades (Coroner.) M. D.

Aug 3/23 192.... (Address) 143 N. Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St. Vincents Cem	8/4 192-3

20-UNDERTAKER. Chas. L. Evans & Son ADDRESS 118 W. Royal Ave

Spec.—1-10-21—M&T—1500 Bks.

D78020

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D78020

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2123 Washington Blvd ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Ellick

(a) RESIDENCE NO. 2123 Washington Blvd ST., 19 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Ellick

6 DATE OF BIRTH (month, day, and year): April 7. 1846

7 AGE: Years 77 Months 3 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Henry Ellick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary Ellick

(Address) 2123 Washington Blvd.

15 Filed . 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8 21 1923

17

I HEREBY CERTIFY, That I attended deceased from 7/28, 1923, to 8/2/, 1923,

that I last saw h[illegible] alive on 8/2/, 1923,

and that death occurred, on the date stated above, at 119 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. Reed Dorsey M. D.

, 19 (Address) 119 West 18th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Aug 6 1923

20 UNDERTAKER: C. W. Dill — ADDRESS 3109 Fredk Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D78021

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D78021

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2103 Fredrick ave St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Peter Perykos

(a) Residence No. 2103 Fredrick ave St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) M

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Oct 1st 1892

7-AGE. 30 yrs. 3 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Bandis

(b) General nature of industry, business, or establishment in which employed (or employer) maker

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Greece

PARENTS.

10-NAME OF FATHER, James Perykos

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Greece

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Greece

14- (Informant) Mrs. Lena Perykos

(Address) 2103 Fredrick ave

15- Filed ..... 192... Robert F. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug-2-23

17- I HEREBY CERTIFY, That I attended deceased from July 20 1923 to Aug 2 1923

that I last saw him alive on Aug 2 1923

and that death occurred, on the date stated above, at 6P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) 1 yrs. ? mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Sea at Sea

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Sputum test

(Signed) James Katzenbach M. D.

19 (Address) per Health Dept. City

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL WOODLAWN CEM. DATE OF BURIAL 8/4 1923

20-UNDERTAKER ROBERT BROOKS & SON ADDRESS COR CALHOUN HOLLINS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D78022

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78022

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1802 Eagle Street St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... John Cumber .....

(a) Residence No. 1802 Eagle Street St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1858

7-AGE. 65 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None .....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Maryland.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town)..... Unknown (State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... Unknown (State or Country),

14-

(Informant)..... L. T. Scally .....

(Address)..... Timonium, Md. .....

15-

Filed ..... 192.....

Robert P. Harrison,
Registrar.

AUG 3 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 2, 1923

17- I HEREBY CERTIFY, That I attended deceased from August 1, ... 1923 to August 2, 1923 that I last saw him alive on ..... August 2, 1923 and that death occurred, on the date stated above, at 7.30P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

.....

.....

.....(Duration) 5 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac asthenia

.....(Duration) ..... yrs. ..... mos. 1 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? H .....

What test confirmed diagnosis? Clinical

(Signed) Edw. T. Coolahan M. D.

8/3, 1923 (Address) 24 N. Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St. Peters Cem.	Aug. 4, 1923
20-UNDERTAKER.	**ADDRESS**
Geo. A. Farley	Fulton & Fayette

B.—WRITE PLAINLY, WITH UNFADING INK. All items must be answered EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. Certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified

Spec.—1-10-21—M&T—1500 Blks.

D78023

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D78023

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1141 Hollins ST., (WARD) 16

2-FULL NAME George H. Leidner

(a) RESIDENCE (No.) 1141 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth G. Leidner

6 DATE OF BIRTH (month, day, and year): Mar. 18-1864

7 AGE — Years: 59 Months: 4 Days: 16 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business, or establishment in which employed (or employer): Barber Shop

(c) Name of employer: Ocean Shop, New York City

9 BIRTHPLACE (city or town) (State or country): [redacted]

PARENTS

10 NAME OF FATHER: Henry Leidner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Eastwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Elizabeth G. Leidner 1141 Hollins St Balto.

15 1923 Robert P. Harrison, Registrar

Vital Statistic Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 2nd 1923

17 I HEREBY CERTIFY, that I attended deceased from August 1st 1923, to August 2nd 1923, that I last saw him alive on August 2nd 1923, and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH was as follows*: Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward C. Reitzel M. D.

8/2, 1923 (Address) 2734 Penna. Ave Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Matthews — DATE OF BURIAL: Aug 4 19

20 UNDERTAKER: John J. Fields — ADDRESS: 1200 W Fayette

G. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. CAUSE OF DEATH is very important. See instructions on back of certificates.

063 - 1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78024

CERTIFICATE OF DEATH.

135 D78024

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 109 S. Calhoun ST., WARD 10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Lehner

(a) RESIDENCE NO. 109 S. Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ellen Lehner

6 DATE OF BIRTH (month, day, and year) Apr. 25 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Johannes Lehner.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Rosina Katherine Tepplerin.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Ellen Lehner (Address) 109 S. Calhoun St.

Filed AUG 3 - 1923 19 Robert F. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2 1923

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1923, to Aug 2, 1923, that I last saw h. alive on Aug 2, 1923, and that death occurred, on the date stated above, at 1.10 A. m.

The CAUSE OF DEATH* was as follows:

Uremia, Cardiac Failure. ?

(duration) yrs. mos da.

CONTRIBUTORY (Secondary) Cardiac Failure. Prostatic obstruction.

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death? 1095 Calhoun St.

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? Clinical Examination

(Signed) Clinton D. Wood M. D.

19 (Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Aug 6 1923

20 UNDERTAKER John J. Field ADDRESS 1100 W. Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78025 D78025

CERTIFICATE OF DEATH.

REGISTERED NO. 29

1-PLACE OF DEATH Volunteers of America Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 415 Wilkins Ave. ST.; WARD 21)

2-FULL NAME Lewis Rund

(a) RESIDENCE. NO. 702 Stockholm ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 10 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Oct 4 - 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	10	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Geo. Rund

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Rund (Address) 1180 Cleveland St

15 Filed AUG 3 - 1923 19 Robert P. Harrison, Registrar

Chief Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1923

17 I HEREBY CERTIFY, That I attended deceased from July 31 1923, to Aug 2nd 1923, that I last saw him alive on Aug 2nd 1923, and that death occurred, on the date stated above, at 8:50 a. m.

The CAUSE OF DEATH* was as follows:

Acute Tetanus

(duration) yrs. mos. ? ds.

CONTRIBUTORY (Secondary) Infected wound following dog-bite.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Observation.

(Signed) H. E. Wells, M. D.

19 (Address) 1521 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk. Cemetery — DATE OF BURIAL 8/4/23

20 UNDERTAKER Geo Lembert & Son. — ADDRESS 647 N. Fremont Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. PHYSICIANS
mation should be carefully supplied. AGE should be stated EXACTLY.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78026

D78026

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1751 Clarkson St.; 23 Ward) 15 W 3

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Horst

(a) RESIDENCE. No. 1751 Clarkson St., W 3 Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Horst

6 DATE OF BIRTH (month, day, and year) Aug. 11-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germy

14 Informant Henry Horst

(Address) 1751 Clarkson st.

15 Filed OCT 3 1923 16 Robert F. Harris, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923 to Aug 2, 1923

that I last saw h alive on Aug 2, 1923

and that death occurred, on the date stated above, at 4-30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. E. Campbell M. D.

Aug 2 1923 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 4 1923
20 UNDERTAKER Schumacher	ADDRESS 1037 Hanover

N. B.—WRITE PLAINLY. WITH PENCIL OR INK. PHYSICIAN'S name and address should be stated EXACTLY. PHYSICIAN should be carefully supplied. AGE should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be understood by clerk of certificates. See instructions on back of certificate. This information is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78027

CERTIFICATE OF DEATH. 131

D78027

REGISTERED NO. Amnia

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hos. ST., 9 WARD)

2-FULL NAME William Amiger

(a) RESIDENCE No. 619 Eutaw Av. Balto ST., WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 11 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Amiger

6 DATE OF BIRTH (month, day, and year) Aug 5th 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	41 yrs.	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 173

(b) General nature of industry, business, or establishment in which employed (or employer) B. & O. R. R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Amiger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant [illegible] (Address) [illegible]

15 Filed AUG 3 1923, 19 Robert P. Merrick, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 2. 1923

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1923, to August 2 1923, that I last saw him alive on August 2, 1923, and that death occurred, on the date stated above, at 10.52 P. m.

The CAUSE OF DEATH* was as follows:

Anuria

Bilateral stone in ureters.

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of aug. 2, 1923

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Edward A. Nidawski, M. D.

19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL aug 6th 1923

20 UNDERTAKER J. Schlosman Son

ADDRESS 1054 [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK MUST BE FILLED OUT EXACTLY. PHYSICIAN should be stated EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be given. Exact information should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Blks.

D78028

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78028

CERTIFICATE OF DEATH.

43

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (No. 1208 Myrtle Ave ST., WARD)

2-FULL NAME Richard Cook

(a) RESIDENCE No. 1208 Myrtle Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard County,
(State or country) Md.

PARENTS

10 NAME OF FATHER Steven Cook.

11 BIRTHPLACE OF FATHER (city or town) Howard
(State or country) County, Md.

12 MAIDEN NAME OF MOTHER Elizabeth Burns

13 BIRTHPLACE OF MOTHER (city or town) Howard
(State or country) County, Md.

14 Informant Estella Cook. (Sister-in-law)
(Address) 408 Dolphin St., City.

15 Filed AUG 3 1923, 19 Robert F. Harrison, Registrar

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1923

17

I HEREBY CERTIFY, That I attended deceased from May 5, 1923, to Aug 2, 1923,

that I last saw him alive on July 28, 1923,

and that death occurred, on the date stated above, at 4 25 p.m.

The CAUSE OF DEATH* was as follows:

Squamous cell carcinoma of
patient was metastasis to
glands of neck.
Sevral.
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
None
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Biopsy.

(Signed) Robert E. Fiske, M. D.

, 19 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 4 1923
20 UNDERTAKER Daniel Easton	ADDRESS City

NB.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE should be stated EXACTLY. PHYSICIANS should mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D78029

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78029

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay View Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Martha Weissner

(Residence in Baltimore: No. 1603 Park Ave St.; yrs. Unknown mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH. July (Month) 31st (Day) 1871 (Year)

7-AGE. 52 yrs. — mos. 2 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). N.Y.

PARENTS.

10-NAME OF FATHER. Solon B. West

11-BIRTHPLACE OF FATHER, (State or Country). N.Y.

12-MAIDEN NAME OF MOTHER. Addie Lan Amon

13-BIRTHPLACE OF MOTHER, (State or Country). N.Y.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs H. Hampton

(Address) 310 E 25th St

15- Filed AUG 4 1923, 192.... Robert F. Harrison, Registrar. Burial Permit Clerk.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 2nd (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and upon (Inquest, autopsy, or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Suicide by Strangulation

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Thos. B. Hooton M. D. Coroner.

Aug 3rd 1923. (Address) Curtis Bay, Balto. Md.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Woodlawn DATE OF BURIAL. Aug 4 1923

20-UNDERTAKER. Wm Cook ADDRESS 502 E North Ave

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78030

CERTIFICATE OF DEATH.

1885 D78030

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Somerset Hospital ST., 18 WARD)

2-FULL NAME Wiley Jones

(a) RESIDENCE NO. 87 N Lemmert ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (~~Wife~~) Lillian May Jones

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Coal Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) West Virginia

PARENTS

10 NAME OF FATHER Charles Jones

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Mary Horn

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) West Virginia

14 Informant (Address) Robert Jones 828 N. Pratt St.

15 Filed AUG 4 1923, 192 Robert P. Garrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 2 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) 1 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Gall Bladder Trouble (duration) ..... yrs. 5 mos. ..... ds.

(Signed) H. S. Gunby, M. D.
(Coroner.)
8-3-23, 192 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 4 1923
20 UNDERTAKER Wm. Cook - 502	ADDRESS E North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78031

CERTIFICATE OF DEATH.

113 D78031

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1908 Fleet ST., 7 WARD)

2-FULL NAME Helen V. Yonezak

(a) RESIDENCE NO. 1908 Fleet ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 6 - 22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank Gonezak

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Emma Heda

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Frank Gonezak
(Address) 1908 Fleet St

15 Filed AUG 4 - 1923, 19 Robert P. Harrison, Registrar

Bureau Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 2, 1923, to Aug. 3, 1923, that I last saw h[illegible] alive on Aug 2, 1923, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

a Intestinal Infection

(duration) yrs. 1 mos 3 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Rehberger M. D.

, 19 (Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Aug 4 1923
20 UNDERTAKER Fred H. Ozazewski	ADDRESS 1930 Eastern

N.B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should be careful to see that the information should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78032

CERTIFICATE OF DEATH.

91-002 D78032

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5404 Cleveland ave ST. 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Jane Dougherty

(a) RESIDENCE NO. 5404 Clevelandave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Dougherty

6 DATE OF BIRTH (month, day, and year) Aug 8 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cecil Co. Md (State or country)

PARENTS

10 NAME OF FATHER Wm Groves

11 BIRTHPLACE OF FATHER (city or town) Cecil Co (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Mercer

13 BIRTHPLACE OF MOTHER (city or town) Cecil Co (State or country) Md

14 Informant (Address) Noah Jefferson 5404 Clevelandave

15 Filed AUG 4 1923 19 Robt F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-1 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan, 1920, to Aug-1, 1923, that I last saw h alive on Aug-1-, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H C Hoen. M. D.

Aug-2, 1923 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. DATE OF BURIAL: Aug. 4 1923

20 UNDERTAKER: Wm E. Black ADDRESS: 927 N Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE should be stated EXACTLY. PHYSICIAN should state mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

165234
D78033

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78033

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 12 WARD)

2-FULL NAME Mrs Edith Morse

(a) RESIDENCE NO. Peabody Apts. Calvert + 30th Sts ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. Unknown · How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~WIFE~~: Mr Herman Morse

6 DATE OF BIRTH (month, day, and year): July 16, 1875

7 AGE: Years 48. Months — Days 23

If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: A. H. Morse

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Laura Blades

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 [illegible] Harriet P. Harrison, Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 3 1923

17

I HEREBY CERTIFY, That I attended deceased from July 21, 1923, to August 3, 1923, that I last saw her alive on August 3, 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Brain tumor - glioma

(duration) 4 yrs. 6 mos ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of July 29-23

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Warfield M Frier, M. D.

8/3, 1923 (Address) J H Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: Aug. 4, 1923

UNDERTAKER: Jno. O. Mitchell,

ADDRESS: 120 W. Fayette St

1164-1923

D78034

HEALTH DEPARTMENT—CITY OF BALTIMORE

112 D78034

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1125 Pamsl Alley St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lottie E. Grimes

(Residence in Baltimore: No. 1125 Pamsl Alley St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH, May 15, 1922
(Month) (Day) (Year)

7-AGE, ... yrs. 2 mos. 12 ds.

If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Wm. Grimes

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER, Nettie Chaney

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nettie Grimes

(Address) 925 N. Gamot St

15-

Filed AUG 4 - 1923 19..

Robert P. Harrison, Registrar.

Mary Truitt Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 21 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Colitis (6 days)

(Duration) ..... yrs. 2 mos. 13 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. C. Blake M. D.

Aug 23 1923 (Coroner) (Address) 1432 E. Biddle

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Pub Cemetery DATE OF BURIAL, Aug 24 1923

20-UNDERTAKER, Jos. H. Deems ADDRESS 1303 Gilmor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78035

CERTIFICATE OF DEATH.

113

D78035

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1145 Stockton ST. 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Henry Williams

(a) RESIDENCE NO. 1145 Stockton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feby 23-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Henry Williams

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Josephine Jewell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Queen Anne's Co. Md

14 Informant Josephine Williams
(Address) 1145 Stockton St

15 Filed AUG 4 1923, 19 Robert F. Harrison, Registrar
Deputy Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1923, to Aug 4, 1923, that I last saw h[illegible]live on Aug 4, 1923 and that death occurred, on the date stated above, at 11.25 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(duration) yrs. mos 5 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Paul Brown, M. D.

8/4 1923 (Address) 1837 Eu. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Aug 4. 1923
20 UNDERTAKER	ADDRESS 725-
Mrs Robert F Elliott	Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY item and information should be carefully supplied. AGE, PLACE OF BIRTH, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78036

CERTIFICATE OF DEATH.

5 129 ✓ D78036

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1136 May ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Boblein

(Residence in Baltimore: No. 1136 May St.; 69 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6-DATE OF BIRTH, Feb (Month) 14 (Day), 1854 (Year)

7-AGE, 69 yrs. 5 mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): ..... N+O

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Washington Boblein

11-BIRTHPLACE OF FATHER (State or Country), [illegible] Md

12-MAIDEN NAME OF MOTHER Louisa Berby

13-BIRTHPLACE OF MOTHER (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Thompson (sister)

(Address) 418 Somerset St

15-

Filed ..... 192.. Robert F. Harrison Registrar.

AUG 4 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 2 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended, deceased from May 1923, to Aug 2 1923, that I saw him alive on Aug 1 1923, and that death occurred, on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Nephritis

(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Marked Anemia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R J Young M. D.

8/3, 1923 (Address) 1424 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery — DATE OF BURIAL, Aug 4, 1923

20-UNDERTAKER Mrs Robert A Elliott — ADDRESS 725 Ashland Ave

N B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78037

CERTIFICATE OF DEATH.

90

D78037

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 538 N. Fulton Ave. ST., 19 WARD)

2-FULL NAME Minnie E. Taxis

(a) RESIDENCE NO. 538 N. Fulton Ave. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick A. Taxis

6 DATE OF BIRTH (month, day, and year) Unknown 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	60	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Mr. Wilson

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Pa.

14 Informant Frederick A. Taxis (Address) 538 N. Fulton Ave.

15 Filed AUG 4 1923, 19 ..... Robert F. Garrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2" 1923

17

I HEREBY CERTIFY, That I attended deceased from May 26, 1923, to Aug 2, 1923, that I last saw her alive on Aug 2, 1923, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) one yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) — yrs. — mos. one ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Stebbins F. Kellerman M. D.

8/2/1923 (Address) 6 E. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 4" 1923
UNDERTAKER Dept. B. Cook	ADDRESS 603 W. Balto St

Spec.—1-10-21—M&T—1500 Blks.

D78038

HEALTH DEPARTMENT--CITY OF BALTIMORE

D78038

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 21 N. Monroe St. ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Virginia Waite

(a) RESIDENCE NO. 21 N. Monroe St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederic S. Waite

6 DATE OF BIRTH (month, day, and year) July 14" 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	0	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER James A. Hogarth

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Lenman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Frederic S. White (Address) 21 N. Monroe St.

15 Filed Aug 4, 1923 Avery F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 1" 1923

17 I HEREBY CERTIFY, That I attended deceased from June 24 1923 to August 1 1923, that I last saw h[illegible] alive on August 1 1923, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. E. Blunt M. D.

8/2, 1923 (Address) 1601 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 4 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Bdlle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DATA must be complete. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78039 HEALTH DEPARTMENT—CITY OF BALTIMORE 49 D78039

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Lombard & Green ST., 316 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Kate Hardesty.

(a) RESIDENCE NO. 811 N Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Divorced

5a If married, widowed or divorced HUSBAND of (or) WIFE of James. Carlton

6 DATE OF BIRTH (month, day, and year) October 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	21	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Hardesty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Emily Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address) Lombard & Green St.

15 Filed Aug. 1923 Robert P. Harrison Registrar

Marital Record Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-1 1923

17 I HEREBY CERTIFY, That I attended deceased from 7-31, 1923, to 8-1, 1923, that I last saw her alive on 8-1, 1923, and that death occurred, on the date stated above, at 1:35 p. m.

The CAUSE OF DEATH* was as follows: operative shock

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sarcomatosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8-1-23

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

8/1, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dixon Park Cem	Aug 4 1923
20 UNDERTAKER	ADDRESS
Joseph B. Cook	603 N. Balto St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION it may be properly classified. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Fore[illegible]," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Cancer of Stomach

Spec.—1-10-21—M&T—1500 Bks.

D78040

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78040

155

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD) 8

2-FULL NAME Herbert E. Midorten

(a) RESIDENCE NO. 1 N. Belair Road ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Nov. 4th 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
14	..	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland -

PARENTS

10 NAME OF FATHER Max Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louis Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Max Martin

(Address) 1 N. Belair Rd. Rosedale

15 Filed AUG 4 1923, 19.. Registrar

Robert P. Garrison, Chief Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-3 1923

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1923, to Aug-3, 1923, that I last saw him alive on Aug 3rd, 1923, and that death occurred, on the date stated above, at 11.5 54 m.

The CAUSE OF DEATH was as follows: *

Purulent Meningitis

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Dental Sinusitis (duration) ... yrs. ... mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of July 21st 1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) R. Kelly Jr M. D.

19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Aug 6 1923

20 UNDERTAKER Beck Lasch & Sons — ADDRESS Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78041

D78041

CERTIFICATE OF DEATH.

141

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bradley.

(a) RESIDENCE NO. 433 Central Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
41	yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. county Md.

PARENTS

10 NAME OF FATHER William Bradley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lizzie Slater

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Annie Moore.

(Address) 433 N Central ave.

15 AUG 4 1923 Robert P. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 2 1923

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1923, to Aug. 2, 1923, that I last saw her alive on Aug. 2, 1923, and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows: Acute Cardiac Dilatation

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Pelvic Inflammatory Disease

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes Date of 8-1-23

Was there an autopsy? No

What test confirmed diagnosis? P.S. and Operation.

(Signed) J. V. Segerbrich, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	aug. 5th 1923

UNDERTAKER	ADDRESS
John. W. Henderson	1502 E Monument St

N.B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78042 1649 32 D78042

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... St., V Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Bricko

(a) RESIDENCE No. 122 S. Wolfe St., Ward
(Usual place of abode)
Length of residence in city or town where death occurred unknown How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 30-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	1	4	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Baby
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER John Bricko

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER A. Konguisko

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Johns Hopkins Hospital
(Address) Records.

15 Filed AUG 4 1923, 19 Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 3 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1923, to August 3, 1923, that I last saw h alive on August 3, 1923, and that death occurred, on the date stated above, at 5:20 a. m.

The CAUSE OF DEATH* was as follows:
Tuberculous Meningitis

(duration) yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal Fluid Findings

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Aug 4 1923
20 UNDERTAKER	ADDRESS
W. M. Fialkowski	618 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. This Blank should be filled out EXACTLY. PHYSICIAN'S mation should be carefully supplied. AGE should be stated CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa- TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78043

D78043

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 36 Hazel St, Curtis Bay ST. 25 WARD)

2-FULL NAME Mary Kutz

(a) RESIDENCE NO. 36 Hazel St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ×

6 DATE OF BIRTH (month, day, and year) Nov 17-1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Kutz

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Urbanska

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Edward Kutz
(Address) 36 Hazel St

15 Filed ..... 19 ..... Registrar

Robert E. Garrison,

U64 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3 1923

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1923, to Aug. 3, 1923.

that I last saw her alive on Aug. 2nd, 1923,

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

General acute miliary tuberculosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Meningeal involvement

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ×

Did an operation precede death? 0no Date of ×

Was there an autopsy? 0no

What ~~was~~ confirmed diagnosis? Diagnosis Childs Specialist confirmed on Aug. 2/23

(Signed) Geo B. Harris M. D.

Aug 3. 1923 (Address) 211 Church St, Curtis Bay,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	Aug 6 1923
20 UNDERTAKER	ADDRESS
Wm Gialkowski	418 Eastern Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78044

CERTIFICATE OF DEATH.

1113 ✓ D78044

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No) 1615 Lorman ST., 15 WARD)

2-FULL NAME Marion Jackson

(a) RESIDENCE NO. 1615 Lorman ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 4 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 16th March 1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
—	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Jackson

11 BIRTHPLACE OF FATHER (city or town) Washington (State or country) D.C.

12 MAIDEN NAME OF MOTHER Beatrice Yost

13 BIRTHPLACE OF MOTHER (city or town) Washington (State or country) D.C.

14 Informant Cornelia Ruth

(Address) 1615 Lorman St

15 Filed AUG 4 1923, 19 ..... Registrar

Robert F. Heffron, Chief Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1923, to Aug 3, 1923, that I last saw h[illegible] alive on Aug 3rd, 1923, and that death occurred, on the date stated above, at 2.30 p m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis (duration) — yrs. — mos 7 ds.

CONTRIBUTORY (Secondary) Carbon Monoxide (duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Edward E Mackenzie M. D.

Aug 4, 1923 (Address) 1339 N Howard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Aug 6 1923
20 UNDERTAKER	ADDRESS
Sam'l H Chase & Son	400 Mosher

N.B.—WRITE PLAINLY, WITH INK. ALL INFORMATION should be stated EXACTLY. PHYSICIAN should state mation should be carefully supplied. AGE should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78045

CERTIFICATE OF DEATH.

D78045

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1517 Covington ST.: 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myra Shaw

(a) RESIDENCE. No. 1517 Covington ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Shaw

6 DATE OF BIRTH (month, day, and year): Jan 22/1858

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	6	"	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Joseph Forrest

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Frederick Shaw
(Address): 1517 Covington St.

15 Filed ..... 19.. Registrar

AUG 4 - 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923, to Aug 2, 1923, that I last saw her alive on Aug 1, 1923, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

Probably (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Enlarged thyroid unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys

(Signed) W. M. Beitzler, M. D.

8/2, 1923 (Address) 1319 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug 4 19
20 UNDERTAKER: Margaret L. Flynn	ADDRESS: 1402 Light St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78046

CERTIFICATE OF DEATH.

D78046

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 Berkley st ST. 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Dorsey

(a) RESIDENCE. NO. 1103 Berkley st ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Fifth yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): April 4 1923

7 AGE: Years — Months: 4 — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto city

PARENTS

10 NAME OF FATHER: Gustus Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: May Healy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Matilda Dorsey
(Address) 1103 Berkley St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 3 1923 to Aug 4 1923, that I last saw h alive on Aug 4 1923, and that death occurred, on the date stated above, at 7.0 P M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Whooping cough

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1103 Berkley

Did an operation precede death? Date of

Was there an autopsy? N

What test confirmed diagnosis?

(Signed) H B Sneak, M. D.

8-5 19 23 (Address) 117 W Saratoga st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 7 19 23
20 UNDERTAKER	ADDRESS
Samuel Stanley	Balto

AUG 4 - 1923 Burial Permit Clerk

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

D78047

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78047

CERTIFICATE OF DEATH.

188-007

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. St. JosephHospital St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ernst Scott

(Residence in Baltimore: No. 1100 E. Monument St. St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	colored	married

6-DATE OF BIRTH. Dec 14/1896 (Month) (Day) (Year)

7-AGE.			If LESS than 1 day,
27 yrs.	7 mos.	18 ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): (General)

9-BIRTHPLACE, (State or Country): Victoria Va.

PARENTS:

10-NAME OF FATHER. Branch Scott

11-BIRTHPLACE OF FATHER, (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Laura Love

13-BIRTHPLACE OF MOTHER, (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Myrtle Scott

(Address) 1100 E. Monument St.

15- Robert P. Harrison,

Filed AUG 4 1923, 192.. Burial Permit Clerk. Registrar.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 1/23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental- Motorcycle accident
Fractured Skull & rt. Thigh.
Inquest to be held Aug. 4/23

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J S H Bolen M. D. (Coroner.)

8/4/23 192.. (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was illsease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Victoria Va DATE OF BURIAL. Aug 5 1923

20-UNDERTAKER, Daniel Wendy ADDRESS 28 Bridge

D78048 HEALTH DEPARTMENT—CITY OF BALTIMORE 198 D78048

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emmanuel Brooks

(Residence in Baltimore: No. 158 Lawrence St. St.; yrs., 2 mos. ds.)

Lawrence

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	single

6-DATE OF BIRTH. October (Month) (Day) 1894 (Year)

7-AGE. 28 yrs. 9 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Pa.

PARENTS.

10-NAME OF FATHER, John Brooks

11-BIRTHPLACE OF FATHER, (State or Country), Pa.

12-MAIDEN NAME OF MOTHER, unknown.

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Garner.

(Address) 15 E. Ware St.

15- Robert F. Hartlaub

Filed ..... 192 ..... Registrar.

AUG 4 - 1923 Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 3 - 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, au- (Inquest, autopsy or Inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stab. Wound Homicide

(Duration) ..... yrs. ..... mos. 1/2 ds.

CONTRIBUTORY (Secondary) Shock & Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Elliott Blacke M. D.

(Coroner)

Aug 4 1923 (Address) 1436 Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Forest Cemetery	Aug 4, 1923.

20-UNDERTAKER, E. Leroy Tiffler ADDRESS 1256 North Ave

Per 3612-24

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Numerals should be used. In stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78049 — CERTIFICATE OF DEATH. — X47 — D78049

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospt. ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Annie Pender

(a) RESIDENCE NO. Edenton N. C. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 4 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Pender (deceased)

6 DATE OF BIRTH (month, day, and year). 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Edenton N C

PARENTS

10 NAME OF FATHER Edw Wood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hertford N C

12 MAIDEN NAME OF MOTHER Carrie Gilliam

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Colerville N C

14 Informant Frankie Wood

(Address) Edenton N C

15 Filed ..... 19 .....

Registrar

UG 4 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 3 1923

17

I HEREBY CERTIFY, That I attended deceased from May 10 . 1923 . to August 3 . 1923

that I last saw her alive on August 3 . 1923 .

and that death occurred, on the date stated above, at 8.25 P. m.

The CAUSE OF DEATH* was as follows:

General Metastases and Cachexia
(Carcinoma of breast)

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5-12-23

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Edward A. Kalowski M. D.

19 Address St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edenton N C

DATE OF BURIAL Aug 4 1923

20 UNDERTAKER ROBERT L BROOKS SON

ADDRESS COR CALHOUN HOLLIS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78050

4/1 D78050

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital. ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelius Robinson

(a) RESIDENCE NO. 1433 Jefferson St

(Usual place of abode) ST., WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1866

7 AGE: Years 57 Months Days If less than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St.Mary's Co., Md.

PARENTS

10 NAME OF FATHER: James Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): St. Mary's Co., Md.

12 MAIDEN NAME OF MOTHER: Anna Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St.Mary's Co., Md.

14 Informant: Municipal Hospital Records. (Address)

15 Filed AUG 5 - 1923 Registrar

CORONER FOR BALTIMORE CITY-EASTERN DISTRICT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 2 1923

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1923, to August 2, 1923, that I last saw him alive on August 2, 1923, and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Infection of right knee.
(Traumatic accidental)

(duration) yrs. mos 23 ds.

CONTRIBUTORY (Secondary) Septicemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Fell on street.

Did an operation precede death? Yes Date of July 27, 23

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) Wm J. Stanton, M. D.

8-3-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cemetery — DATE OF BURIAL: Aug 5 1923

20 UNDERTAKER: Mrs Chas. G. Bailey — ADDRESS: 1421 Jefferson St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DATA must be given for all items. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D78051

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D78051

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 105 N. Payson St. St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lemuel E. Bird.

(a) Residence No. 105 N. Payson St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of V. A. Ewig Bird

6-DATE OF BIRTH (month, day and year) Aug. 25, 1884

7-AGE.	If LESS than 1 day,
38 yrs. 11 mos. 8 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Engineer

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto.
(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Horace S. Bird

11-BIRTHPLACE OF FATHER (city or town) A. A. Co.
(State or Country),

12-MAIDEN NAME OF MOTHER, Agnes Sylvester

13-BIRTHPLACE OF MOTHER (city or town) Wash. D. C.
(State or Country),

14- (Informant) Alvan C. Bird

(Address) 105 N. Payson St.

AUG 5 - 1923 ROBERT R. KRAUTER
Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 2, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 21, 1923 to July 30 1923

that I last saw him alive on " " 1923

and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cardiac Hypertrophy

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilitation of Heart

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. J. Cookahan M. D.

8/4 1923 (Address) 24 N. Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (I) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Aug. 6 1923

20-UNDERTAKER.	ADDRESS
John O. Mitchell	1201 W. Fayette St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78052

CERTIFICATE OF DEATH.

12 4 D78052

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wisniewski

(a) Residence No. 1018 S. Decker St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1859

7-AGE. 63 yrs. mos. ds. If LESS than 1 day hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Stevedore

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Stanislaw Wisnkewski

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Municipal Hospital Records

(Address)

15-

Filed AUG 5 - 1923 19... ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) August 3, 1923

17- I HEREBY CERTIFY, That I attended deceased from March 2 19 23 to August 3 19 23

that I last saw him alive on August 3 19 23

and that death occurred, on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH* was as follows:

Acute Chalecystitis,
Chronic empyema, antherit.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude G. Dixon M. D

8-3-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
St Mary Gemin Hall Road	Aug 6 1923
20-UNDERTAKER.	ADDRESS
Wendell Eppleson	378 N

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78053

CERTIFICATE OF DEATH.

49 D78053

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 307 Myrtle Av ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes McLaud

(a) RESIDENCE NO. 307 Myrtle Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: negro | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: John McLaud

6 DATE OF BIRTH (month, day, and year): 1876

7 AGE: Years 47 | Months | Days | If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Calvert Co. Md.

PARENTS

10 NAME OF FATHER: Wm Hurlitz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Susan Carey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mr John Lauland

(Address)

15 Filed AUG 5 - 1923 19 ROBERT R. KRAUTH Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/2/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 6/1/ 1923 to 8/2/ 1923, that I last saw her alive on Aug 1st 1923, and that death occurred, on the date stated above, at 6.15 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Hip with metastasis in abdominal & thoracic viscera

Duration of disease ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? X Ray

(Signed) P. L. Jackson M. D.

8/2, 1923 (Address) 767 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. | DATE OF BURIAL: 8/5 1923

20 UNDERTAKER: Samuel Hemsley | ADDRESS: 578 N Pine St

N.B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-003 D78054

CERTIFICATE OF DEATH.

D78054

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 N. Washington ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William David Bell.

(a) RESIDENCE. No. 507 N. Washington ST., 7 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma C. Bell.

6 DATE OF BIRTH (month, day, and year) Aug 7- 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	0	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Hugh Bell.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Conn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Margaret Finney (Address) 507 N. Washington St.

15 Filed AUG 5 1923 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1923

17 I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19..., that I last saw h... alive on April 1923, 19..., and that death occurred, on the date stated above, at 8.20 A. m.

The CAUSE OF DEATH* was as follows:
Hodgkins Disease. Arteriosclerosis
Emphysema, Myocardial Insufficiency (Chronic)
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gland excision

(Signed) Chas. W. Cummings M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Aug 6 1923
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Mo. Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78055

161-001

D78055

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 S. Bouldin St. ST.: 26 WARD)

2-FULL NAME Charles P. Schisler

(a) RESIDENCE. No. 1017 S. Bouldin ST., 26 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 2-1923.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	0	0	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Philip P. Schisler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary E. Kalbfleisch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) Philip P. Schisler 1017 S. Bouldin St

15 Filed AUG 5 - 1923 19 ROBERT R. KRACTER. Registrar Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1923, to August 4, 1923, that I last saw h[illegible] alive on Aug 2, 1923, and that death occurred, on the date stated above, at 7.10 P. m.

The CAUSE OF DEATH* was as follows:

Premature 7 months
Foetus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

8/ (Signed) Hanaes Tilton, M. D.

8/ 1923 (Address) 315 S Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Aug 5 1923
20 UNDERTAKER Lilly and Zeiler	ADDRESS 403 S. Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D78056

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78056

CERTIFICATE OF DEATH.

31

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. ..... St., Municipal tuberculosis Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME....Ida Fleming.....

(a) Residence No. 924 Decker ave. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Walter W. Fleming

6-DATE OF BIRTH (month, day and year) April 19 189? ?

7-AGE. 29 ? yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, James Omsaen

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Norway

12-MAIDEN NAME OF MOTHER, Maggie Fick

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Maryland

14- (Informant)..... Hospital Records

(Address)..... M.T.H.

15- Filed AUG 5 - 1923 ROBERT R. KRAUTER, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 3, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 11 1923 to Aug. 3 1923

that I last saw her alive on Aug. 3 1923

and that death occurred, on the date stated above, at 10.15 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? T.B. in sputum, X-ray

(Signed) L. A. Lalley M. D.

8-4-23 19 (Address) Municipal Tbc. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mt Carmel	Aug 6 1923
20-UNDERTAKER, Wm Cook	ADDRESS 502 E North

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78057

CERTIFICATE OF DEATH.

114

D78057

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE—(No.) 1031 N. Gay ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth M. Williams

(a) RESIDENCE NO. 1031 N. Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 23-1918

7 AGE: Years 5 Months 4 Days 12 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles H Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Hilda M. Barnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Charles H. Williams (Address) 1031 N. Gay

15 Filed AUG 5 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/4 1923

17 I HEREBY CERTIFY, That I attended deceased from 8-3- 1923 to 8-4 1923.

that I last saw her alive on 8-4- 1923

and that death occurred, on the date stated above, at 5555 m.

The CAUSE OF DEATH* was as follows:

Uter Colitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Myocardial Insuff

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Weiss, M. D.

, 19 (Address) 1063 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: M.V. Church

DATE OF BURIAL 8/6 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E Nath

N. B.—WRITE PLAINLY with indelible pencil. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Dr Bowe 90 4 N Charles

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78058

CERTIFICATE OF DEATH.

58-601 D78058

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2501 West Fayette ST., (WARD)

2-FULL NAME Ida J. White

(a) RESIDENCE No. 2501 West Fayette ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 9 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Hanson C. White

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary E. Harbeycutter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Harry S. White

(Address) 2501 W. Fayette

15 Filed AUG 5 1923 19 HERBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3 - 1923.

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1923, to Aug. 3 - 1923, that I last saw h[illegible] alive on Aug. 3, 1923, and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Pernicious anemia.

(duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) — yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Lab. Blood Exam.

(Signed) Dudley P. Bowe, M. D.

19 (Address) 90 4 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cemetery

DATE OF BURIAL: Aug 4th 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E Nor

I. B.—WRITE PLAINLY, with ordinary pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

DARK

Spec.—1-10-21—M&T—1500 Bks.

D78059

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 D78059

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3253 Chestnut Ave (ST.,) 13 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Almira L Ulmar

(a) RESIDENCE NO. 3253 Chestnut Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of William L Ulmar

6 DATE OF BIRTH (month, day, and year) Oct 22-1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Jos. Krout

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Eliza Low

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mr. Wyman (Address) 3253 Chestnut Ave

15 Filed AUG 5 - 1923, 19 ROBERT R. KRAUTH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1923

17

I HEREBY CERTIFY, That I attended deceased from August 2nd, 1923, to August 3rd, 1923, that I last saw h~~im~~er alive on August 2nd, 1923, and that death occurred, on the date stated above, at 12 45 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Vulva

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? L

Did an operation precede death? Yes Date of June 1920

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) William G. Clayton, M. D.

, 19 (Address) 2919 Huntingdon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Aug 6 1923

20 UNDERTAKER	ADDRESS
A B Marshall	3539 Gall Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Fannie Felberbaum.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78060

CERTIFICATE OF DEATH.

57 D78060

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. H. O. ST.: 17 WARD)

2-FULL NAME Mrs Fannie Felberbaum

(a) RESIDENCE. NO. 2235 Barclay ST.. ....WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Max Felberbaum

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 48 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Max Villk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Leurs 1439 Eutaw St

15 Filed AUG-5 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5 1923.

17 I HEREBY CERTIFY, That I attended deceased from July 17 1923 to Aug 5 1923.
that I last saw her alive on Aug 5 1923
and that death occurred, on the date stated above, at 8.50A. m.
The CAUSE OF DEATH* was as follows:

Pulmonary edema

(duration) yrs. mos. 11 hrs.

CONTRIBUTORY (Secondary) Diabetes Mellitus & Myocardial Degeneration (duration) 4 yrs mo.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Aug 31, 1923

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Adolf Sondheimer M. D.

, 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Sinai — DATE OF BURIAL: 8 1923

20 UNDERTAKER: Jack Leurs — ADDRESS: 1439 Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78061

CERTIFICATE OF DEATH.

161-001 ✓ D78061

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Libinson

(a) RESIDENCE. NO. 5703 Clemmore Clos WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			2½	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Meyer Libinson

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Hinda Schapiro

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Hospital Records
(Address)

15 Filed AUG 5 - 1923 ROBERT R. KRAETZER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9, 1923

17

I HEREBY CERTIFY, That I attended deceased from July 7, 1923, to July 9, 1923,
that I last saw h[illegible] alive on July 9, 1923,
and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Premature Baby - weight at birth 2 lb. 6 oz.

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A Stoller Sondheimer, M. D.

, 19 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 8/5 1923

20 UNDERTAKER Jack Levis 1439 E Balto

ADDRESS

Burial Permit Check

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78062

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78062

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 696 N. Mulberry ST., 17 WARD)

2-FULL NAME Ruth Hyatt

(a) RESIDENCE NO. 696 N. Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 10 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 3 1922

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Max Hyatt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Bessman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Mrs. Ethel Hyatt.
(Address) 696 N. Mulberry St.

15 Filed AUG 5 1923, 19... ROBERT A. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923, to Aug 5, 1923, that I last saw her alive on Aug 4, 1923, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph Sindler, M. D.

, 19 (Address) 2359 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 8/5 1923

20 UNDERTAKER Jack Lewis 1739 E Balto St

ADDRESS

N. B.—WHITE PAPER, WITH CARBON IMPRESSION SHEET, FURNISHED FREE. Every question should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78063

CERTIFICATE OF DEATH.

196 D78063

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Md Gen'l Hospital St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Albert Matthias

(Residence in Baltimore: No. 3304 Chestnut Ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.)

6-DATE OF BIRTH, Dec 23 1911
(Month) (Day) (Year)

7-AGE, 11 yrs. 7 mos. 11 ds.

If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... School Boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER Harry E Mathias

11-BIRTHPLACE OF FATHER, (State or Country), Md

12-MAIDEN NAME OF MOTHER Edith Crook

13-BIRTHPLACE OF MOTHER, (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry E Mathias

(Address) 3304 Chestnut Ave

AUG 5 - 1923

Filed..... 192.....

ROBERT R. KRAUTER, Registrar.

Burial Permit Given

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 3 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Electric Shock,
Accident.

(Duration) yrs. mos. 2d

CONTRIBUTORY (Secondary)

(Duration) mos. ds.

(Signed) Geo Clinton Blades M. D.
(Coroner.)

192.... (Address) 143 Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cem. DATE OF BURIAL, Aug. 6 1923

20-UNDERTAKER, CHENOWETH & SON, ADDRESS 3617 CHESTNUT AVE.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Became Locked & fell a distance of about 18 Feet Death 2 Hrs. body released 5 Hrs.

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78064

CERTIFICATE OF DEATH.

74001 ✓ D78064

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1804 Harlem Ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Emmart Stoddell

(a) RESIDENCE NO. 1804 Harlem Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Jno Estle Stoddell

6 DATE OF BIRTH (month, day, and year) Apr 22 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Cigar Factory

(c) Name of employer Chas H. Harkins

9 BIRTHPLACE (city or town) (State or country) Md Balto

PARENTS

10 NAME OF FATHER Samuel Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louise Emmart

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mrs Thompson Coleman 1804 Harlem Ave

15 AUG 5 - 1923 ROBERT R. KRAUTER, Burial Permit Director

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3 1923

17 I HEREBY CERTIFY, That I attended deceased from June, 1923, to Aug 3, 1923, that I last saw him alive on Aug 3, 1923, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) about 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Mchenry

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Frank E Lewis M. D.

, 19 (Address) 1501 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: 8-5 19

20 UNDERTAKER: J. Adam Lee — ADDRESS: 1123 Park Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78065

CERTIFICATE OF DEATH.

90 D78065

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Frisch

(a) RESIDENCE NO. 529 N. Luzerne ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

should be stated EXACTLY. PHYSICIANS should state may be properly classified. Exact statement of OCCUPA- back of certificates.

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Benj. Frisch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Ida L. Woodall

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Benj. Frisch (Address) 529 N. Luzerne Ave

15 Filed AUG 5 - 1923 ROBERT T. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5- 1923

17 I HEREBY CERTIFY, That I attended deceased from July-30-, 1923, to August 5, 1923, that I last saw him alive on August 5, 1923, and that death occurred, on the date stated above, at 1.15 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis.

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

Left Side Paralysis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. J. Parr, M. D.

, 19 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem. DATE OF BURIAL 8/6/1923

20 UNDERTAKER David Sondheim ADDRESS 118 W. Mt. Royal Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78066

CERTIFICATE OF DEATH.

113

REGISTERED NO. D78066

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 E Chase ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nicholas. E Graf

(a) RESIDENCE NO. 1520 E Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 25 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Nicholas. E. Graf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mildred Hallorant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr. Charles Graf

(Address) 1520 E Chase st

15 Filed ..... 19 ..... ROBERT R. KRAMER Registrar

AUG 6 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 3 1923, to Aug. 4 1923.

that I last saw h[illegible] alive on Aug 4 1923

and that death occurred, on the date stated above, at 11 40 a.m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

In attendance

(duration) 1 yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. A. Mettee M. D.

1923 (Address) 1031 N. Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 6 1923
20 UNDERTAKER	ADDRESS
Henry Hoen & Son	1301 E Eager st

N. B.—WRITE PLAINLY. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Boman

D78067

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

40 D78067

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 520 Addison Alley St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F. Boman

(Residence in Baltimore: No. 520 Addison Alley St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH.

..... 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day.
60 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

9-BIRTHPLACE, (State or Country). Newport-Charles Co Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Matilda Boman

13-BIRTHPLACE OF MOTHER, (State or Country). Newport-Charles Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Boman

(Address) 520 Adison Alley

15- AUG 6 - 1923 ROBERT R. KRAUTER Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 3 - 23
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) Geo Clinton Blades M. D.
(Coroner)

Aug 5 1923 (Address) 1436 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Saint Peters Cemetery	Aug 6 1923
20-UNDERTAKER. Mrs Robert A Elliott	ADDRESS 1725 Ashland Av

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78068

CERTIFICATE OF DEATH.

113 ✓ D78068

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1235 S. Decker Ave 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Joseph Korzeniewski

(a) Residence No. 1235 S. Decker Ave St.; Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	—

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug. 10, 1922

7-AGE.	If LESS than 1 day,
....yrs. 11 mos. 26 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Maryland.

PARENTS.

10-NAME OF FATHER, Walter Korzeniewski

11-BIRTHPLACE OF FATHER (city or town) Poland
(State or Country),

12-MAIDEN NAME OF MOTHER, Catherine Zubrowska

13-BIRTHPLACE OF MOTHER (city or town) Balto.
(State or Country), Md.

11- (Informant) Walter Korzeniowski

(Address) 1235 S. Decker ave

13- Filed AUG 6 - 1923 ROBERT R. KRAUER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 5, 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug 4, 1923 to Aug 5, 1923

that I last saw him alive on Aug 4, 1923

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Infantile Diarrhea

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P S & S

(Signed) John J Krager M. D

. 19 (Address) 2627 Eastern Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Stanislaus	Aug 6, 1923
20-UNDERTAKER.	ADDRESS
John M Weber	1803 Bank

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78069 D78069

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1621 Argyle Av St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Rick

(Residence in Baltimore: No. 1621 Argyle St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Fem	Col.	Single

6-DATE OF BIRTH Sept 25 1923
(Month) (Day) (Year)

7-AGE, yrs. 5 mos. 14 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Philip Rick

11-BIRTHPLACE OF FATHER, (State or Country), Va

12-MAIDEN NAME OF MOTHER, Marie Lee

13-BIRTHPLACE OF MOTHER, (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Philip Rick

(Address) 1621 Argyle Ave

15- AUG 6 - 1923 ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 5 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intestinal Rickets

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) J. C. Blades M. D.
(Coroner.)

(Address) 145 Hedney

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Mt Auburn — DATE OF BERIAL, Aug 6 1923

20-UNDERTAKER Sam'l H. Chase & Son — ADDRESS 1400 Mecher

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78070

CERTIFICATE OF DEATH

100-001 D78070

1-PLACE OF DEATH 1516 N Durham St 8

CITY OF BALTIMORE: (No.) 1516 N Durham ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August F Keeling

(a) RESIDENCE No. 1516 N Durham ST., 8 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. 4 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Mar 20 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	51	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hustler (Huckster)

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George C Keeling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Jamie Kennick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Margaret Keeling. (Address) 1516 N Durham

15 Filed AUG 6 - 1923 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 4 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to Aug 4, 1923

that I last saw him alive on Aug 4, 1923

and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH was as follows:

Bronchio-pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) 1 yrs. about mos. ds.

18 Where was disease contracted if not at place of death? Dont Know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Signs

(Signed) A W Macdonald, M. D.

Aug 4, 1923 (Address) 1540 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Aug 6 1923

20 UNDERTAKER: Robt J Turner Inc — ADDRESS 1942 E Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78071

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78071

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1652 N. Monroe St., 15 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Barnett Cockrell

(Residence in Baltimore: No. 1652 N. Monroe St.; yrs. abt 50 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH, Oct. (Month) 12 (Day) 1861 (Year)

7-AGE, 61 yrs. 9 mos. 21 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Steamboat Capt
(b) General nature of industry, business, or establishment in which employed (or employer) Bdwy Ferry

9-BIRTHPLACE, (State or Country). Va.

PARENTS.

10-NAME OF FATHER, Noah Cockrell

11-BIRTHPLACE OF FATHER, (State or Country). Va

12-MAIDEN NAME OF MOTHER, Winny Ann Crowell

13-BIRTHPLACE OF MOTHER, (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Anna M Cockrell

(Address) 1652 N. Monroe

15- AUG 6 1923 Filed.

ROBERT R. KRAUTH, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 2 (Day) 192 3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to... death on the day stated above.

The CAUSE OF DEATH* was as follows:

A Foplexy

(Duration) yrs. mos. 1 hrs

CONTRIBUTORY (Secondary) Bowels Complication

(Duration) yrs. mos. ds.

(Signed) Geo Edwin Wades M. D.

(Coroner.)

Aug 16 192 (Address) 26 Bway

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Loudon Park Aug 6 1923

20-UNDERTAKER, Wm J Tickner & Sons ADDRESS North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D78072

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D78072

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 574 Gold St., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Ragland

(a) RESIDENCE NO. 574 Gold ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of King D. Ragland

6 DATE OF BIRTH (month, day, and year) June 9, 1878

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
45	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Belair (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Osborne

11 BIRTHPLACE OF FATHER (city or town) Belair (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant King D. Ragland (Address) 574 Gold St

15 Filed AUG 6 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3, 1923

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1923, to Aug 3rd 1923 that I last saw h[illegible] alive on Aug 3rd 1923, and that death occurred, on the date stated above, at 7:15 a. m.

The CAUSE OF DEATH* was as follows:

Cal. V. D.

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinique

(Signed) R. Lee Chin. M. D.

8/3, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Asbury Cem. DATE OF BURIAL Aug 6 1923

20 UNDERTAKER Samuel T. Hemsley ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78073

CERTIFICATE OF DEATH.

113 · D78073

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3303 Marshall Court ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie L. Earhardt

(a) RESIDENCE No. 3303 Marshall Court WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 5 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 16 /23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER William Earhardt

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER E Dittaman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mrs E. Earhardt (Address) 3303. Marshall Court.

15 Filed AUG 6 1923 ROBERT R. KRAUER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923, to Aug 1, 1923

that I last saw h[illegible] alive on Aug 1, 1923

and that death occurred, on the date stated above, at 3.P.M.

The CAUSE OF DEATH* was as follows:

Acute Illes - Collitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John H. Ames M. D.

Aug 6, 1923 (Address) 35 N. Poloma St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sinai Cemetery.	Aug. 6 1923
20 UNDERTAKER	ADDRESS
Geo. J. Burke	1735 Harford Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D78074

CERTIFICATE OF DEATH.

D78074

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 928 Vincent ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Sweetenburg.

(a) RESIDENCE NO. 928 Vincent ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Sweetenburg

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	+	+	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 70

(b) General nature of industry, business, or establishment in which employed (or employer) Homemaker

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant William Sweetenburg (Address) 928 Vincent.

15 AUG 6 - 1923 ROBERT A. KRANTZ, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 3 1923

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1923, to Aug 3, 1923.

that I last saw h[illegible] alive on Aug 1, 1923,

and that death occurred, on the date stated above, at 4. a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy into Medulla Oblongata

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Gastro-Enteritis

(duration) — yrs. 2 mos. + ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? None Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Charles E. Clark, M. D.

Aug 3 1923 (Address) 1306 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Lawn

DATE OF BURIAL 8-7 1923

20 UNDERTAKER Daniel Eastern

ADDRESS 916 [illegible]

AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATIONS on back of certificates.

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that TION is very important. See instructions o

D78075

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78075

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 Whatcoat ST. 16 WARD)

2-FULL NAME Mary E. Johnson

(a) RESIDENCE. NO. 809 Whatcoat WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Johnson

6 DATE OF BIRTH (month, day, and year) July 9-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	—	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook. 21

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS

10 NAME OF FATHER Wm Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md.

12 MAIDEN NAME OF MOTHER Mahoney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md

14 Informant Nellie Doran

(Address) 923 N. Bassett

15 Filed .. 19 ROBERT R. KRAETER, Registrar

AUG - 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 - 19 23

17

I HEREBY CERTIFY, That I attended deceased from June 26, 1923, to Aug 3, 1923, that I last saw h.. alive on Aug 2, 1923, and that death occurred, on the date stated above, at 7. A m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(duration) yrs. 3 mos. 7 ds.

CONTRIBUTORY (Secondary) Gastritis.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? *

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) F. O. Lynch, M. D.

Aug 3 19 (Address) 1116 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	8-6-19 23
20 UNDERTAKER	ADDRESS 916 Eutaw
David Earlon	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78076 — 74-001 — D78076

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 N. Gilmor ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Bell

(a) RESIDENCE No. 111 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced, HUSBAND of Kate Bullock Bell

6 DATE OF BIRTH (month, day, and year) Jan. 2. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): house building

(c) Name of employer: self

9 BIRTHPLACE (city or town) (State or country): Anne Arundle Co. Maryland

PARENTS

10 NAME OF FATHER: James Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Anne Arundle Maryland

12 MAIDEN NAME OF MOTHER: Annie Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Anne Arundle Co Maryland

14 Informant: Kate Bell

(Address): 111 N. Gilmor St.

15 Filed AUG 6 - 1923 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1923

17 I HEREBY CERTIFY, That I attended deceased from July 27 1923 to Aug 3 1923

that I last saw him alive on Aug 3 1923

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 4 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. R. Duvall, M. D.

8/3 1923 (Address) 1817 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	8-6-23 19
20 UNDERTAKER	ADDRESS
H. E. Hughes	424 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

165382. D78077

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78077

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 14 WARD)

2-FULL NAME Bertha Hill

(a) RESIDENCE NO. 403 Robert St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown Life How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 30-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Ellsworth Taylor.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Helen Hill.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records JOHNS HOPKINS HOSPITAL (Address)

15 Filed AUG 6 - 1923 ROBERT B. KRAUTER, Registrar Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4 1923

17 I HEREBY CERTIFY, That I attended deceased from July 28 1923 to August 4 1923 that I last saw her alive on August 4 1923 and that death occurred, on the date stated above, at 4:00 A.m.

The CAUSE OF DEATH* was as follows:

Diarrhoea - Toxic Dysentery

(duration) yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes-

What test confirmed diagnosis? None

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL Aug. 6, 1923

20 UNDERTAKER John M. Johnson — ADDRESS 1509 Druid Hill Ave

GE should be stated EXACTLY. PHYSICIANS should state
t it may be properly classified. Exact statement of OCCUPA-
on back of certificates.
mation should be carefully supplied. AGE sh
CAUSE OF DEATH in plain terms, so that it m
TION is very important. See instructions on b

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78078 ✓ 31 D78078

CERTIFICATE OF DEATH.

D78078

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2954 Presstman ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert J Higgins

(a) RESIDENCE. No. 2954 Presstman ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 1, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Robert R Higgins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Bertha E. Langley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): Robert R Higgins 2954 Presstman St

15 Filed AUG 6 - 1923 ROBERT E. KRAUTH Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) AUG 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Aug 5, 1923, that I last saw h~~i~~s alive on Aug 5, 1923, and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ——→

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) W. S. Hebb, M. D.

AUG 5 1923 (Address) 2220 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Woodlawn — DATE OF BURIAL AUG 7 1923

20 UNDERTAKER Geo W Little — ADDRESS 2700 BOSTON AVE

AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78079

CERTIFICATE OF DEATH.

D78079

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1341 (St.) A Gay (Ward) 8

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna M. Giles

(a) RESIDENCE. No. 1341 St Gay ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ (HUSBAND) of (or) WIFE of Charles A. Giles

6 DATE OF BIRTH (month, day, and year) Feb 24 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Swagler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Annie Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Charles A. Giles

(Address) 1341 A Gay St

15 Filed ..... 19.....

ROBERT J. KANEY, Registrar,

AUG 6 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) AUG 4 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 1 1923, to Aug 4 1923.

that I last saw h[er] alive on Aug 4 1923.

and that death occurred, on the date stated above, at 9.10 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(duration) 1 yrs. 7 mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Jan 1 1923

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) M. E. Wagner M. D.

(Address) AUG 5 1923 1301 A Patterson Park Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore DATE OF BURIAL AUG 7 1923

20 UNDERTAKER Geo W Little ADDRESS 2700 Edmondson Ave.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D78080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

23 D78080

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1509 W. Lexington ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William L. Cutaiar

(Residence in Baltimore: No. 1509 W. Lexington Sts. St.; ....yrs., ...mos. ....ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
male	White	Married

6-DATE OF BIRTH, ... July (Month) 9th (Day), 1863 (Year)

7-AGE,	If LESS than 1 day,
60 yrs. ..... mos. 26 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Clerk, 5 09
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Paint Store

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Francis Cutaiar

11-BIRTHPLACE OF FATHER (State or Country), Phila. Pa.

12-MAIDEN NAME OF MOTHER Louise Love

13-BIRTHPLACE OF MOTHER (State or Country), Phila. Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Ida L. Cutaiar

(Address) 1509 W. Lexington St.

15- AUG 6 - 1923 ROBERT R. KRAUTER, Filed ..... 19.. Burial Permit Issued ..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... Aug. (Month) 4th (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 1st 1923, to Aug 3rd 1923, that I saw him alive on Aug 3rd 1923, and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of tongue

(Duration) ....yrs. 18 mos. ....ds.

CONTRIBUTORY .....
(Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. C. Dickson M. D.

Aug 6th, 1923 (Address) 3055 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Aug 7, 1923
20-UNDERTAKER,	ADDRESS
George L. Schwab & Bro.	Baltimore

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78081

CERTIFICATE OF DEATH.

100-001

D78081

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William B. Medford

(a) RESIDENCE NO. 776 St. Peter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 17-1919

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	3	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Jesse A. Medford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louise A. Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jesse A. Medford (Address) 776 St. Peter St.

15 Filed AUG 6 1923, 19 ROBERT A. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5- 1923

17 I HEREBY CERTIFY, That I attended deceased from 8-2-, 1923, to 8-5-, 1923, that I last saw him alive on 8-5-, 1923, and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X ray & Blood Culture

(Signed) H. L. Penn, M. D.

8-5-, 1923 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Bluff Cemetery Md Long	8 1923
20 UNDERTAKER	ADDRESS
George L. Schwab	2101 Eutaw Pl.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78082

CERTIFICATE OF DEATH.

3 ✓ D78082

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 N. Eden ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara H Donavan

(a) RESIDENCE NO. 616 N Eden ST., 5 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 17th 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Lauers

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Dennis Donovan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Ann Leyden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Dennis Donovan (Address) 616 N Eden St

15 AUG 6 - 1923 Registrar ROBERT R. KRAUTER, Burial Permit Recorder

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 8th, 1923, to July 30, 1923, that I last saw h alive on July 30, 1923, and that death occurred, on the date stated above, at 7 30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Edw H Brennan M. D.

(Address) Overlea Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem DATE OF BURIAL Aug 7 1923

20 UNDERTAKER Geo M. Funk Son ADDRESS 811 N Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Blks.

D78083

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1681 Cliefview Ave. 8 WARD)

REGISTERED No. 129 D78083

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Edw. Pipins

(a) RESIDENCE No. 1681 Cliefview Ave. WARD 8

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 4-1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	6	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Brass Finisher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: 810

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Chas. Pipins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Jennie Stout

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Jennie Stevens (Address) 1681 Cliefview Ave

15 Filed AUG 6 - 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4" 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 3 . 1923 . to Aug 4 . 1923 .

that I last saw him alive on Aug 4 . 1923 .

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Urine analysis

(Signed) J. Fisher, M. D.

8/6, 1923 (Address) 1820 N. West. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem — DATE OF BURIAL: Aug 7" 1923

20 UNDERTAKER: Geo M. Fisher & Son — ADDRESS: 811 N. Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

Peachey Simms

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78084

CERTIFICATE OF DEATH.

90 V D78084

1-PLACE OF DEATH

REGISTERED No. C.....

CITY OF BALTIMORE: (No. Ridgely St near Centre St; Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peachey Simms

(Residence in Baltimore: No. Ridgely St St.; 50 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	Colr	Married

6-DATE OF BIRTH, — (Month) — (Day) 1— (Year)

7-AGE, 68 yrs. m.s. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Va

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), Va

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lonza Simms

(Address) Mt Winans

15- AUG 6 1923 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 3 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...

that I saw h... alive on — 191...

and that death occurred, on the date stated above, at ...

The CAUSE OF DEATH* was as follows:

Volvular Heart disease

Died without a Doctor

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary) Cardiac dropsy

(Duration) ...yrs. ...mos. ...ds.

(Signed) Wm Hack

8-4..., 1923 (Address) Hazelhurst

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State 23 yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence Mt Winans

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cemetery — DATE OF BURIAL, Aug 6, 1923

20-UNDERTAKER Mrs Geo H Hooper — ADDRESS 406 W. Conway St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D78085

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

4-9-02 D78085

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1642 N Gilmor St., 45 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Bates

(Residence in Baltimore: No. 1642 N Gilmor St.; 40 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Female	Colored	Widowed

6-DATE OF BIRTH.

unknown 1857
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
66 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country). unknown

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country). unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W Brown

(Address) 108 N Montgomery

15-
Filed AUG 6 - 1923 ROBERT R. KRAMER, Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, July 31 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows:

Chr Bronchitis

Contributory (Secondary) Exhaustion (Duration) yrs. 2 mos. ds.

(Duration) yrs. mos. 1 ds.

(Signed) G C Keidel M. D.
(Coroner)

1923 (Address) 1458 Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn R R	Aug 7 - 1923
20-UNDERTAKER.	ADDRESS
C. D. Brown & Son	108 N Montgomery

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

165-H14 D78086

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14-002 D78086

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence Carpenter

(a) RESIDENCE NO. Fairmont ST., WARD W. Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 day yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 10-1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	21	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER David

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Minnie Neat

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL.

15 Filed AUG 6 1923 ROBERT R. KRAUTER Registrar
Burial Permit Given

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5 1923

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1923, to August 5, 1923.

that I last saw h alive on August 5, 1923

and that death occurred, on the date stated above, at 1 10 p. m.

The CAUSE OF DEATH* was as follows:

Aubcal Embolus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Rheumatic fever, Poor Circulation (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas. W. Cousins M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairmont W Va

DATE OF BURIAL 8/6 1923

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78087

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78087

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Church Home & Infirmary ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Hyman Shapiro

(a) RESIDENCE NO. 2473 Druid Hill, ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Rebecca Shapiro

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Shapiro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ruth —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Rebecca Shapiro
(Address) 2473 Druid Hill Ave

15 Filed AUG 6 1923, 19 HARRY R. KHOEL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1923

17

I HEREBY CERTIFY, That I attended deceased from June 3, 1923, to Aug 5, 1923, that I last saw h[illegible] alive on Aug 5, 1923 and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of June 5th

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) R. G. Coblentz, M. D.

, 19 (Address) Church Home and Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rehrem Memorial Park	Aug 6 1923
20 UNDERTAKER Jack Levin	ADDRESS 514 E Balto St

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78088 ✓ 31 D78088

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 631 Euclid Ave. St., Roland Park 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Patterson

(a) RESIDENCE NO. 631 Euclid Avenue ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 0 mos. 27 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) July 7, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Doctor - Pharmacy

(b) General nature of industry, business, or establishment in which employed (or employer) 025

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William F. Patterson

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie E. Lawson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Miss Margaret Patterson
(Address) 631 Euclid Avenue

15 Filed AUG 6 1923 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 4- 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug- 2 1921 to Aug 4 1923.
that I last saw her alive on Aug. 4 1923.
and that death occurred, on the date stated above, at 12-30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 22- yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. - mos. ds.

18 Where was disease contracted / If not at place of death? .....

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) M. Gibson Parker M. D.

8/6. 1923 (Address) 422 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 8/7 1923

20 UNDERTAKER: Henry W. Mears & Son — ADDRESS: 805 N. Calvert

Spec.—I-10-21—M&T—1500 Bks.

D78089

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78089

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2809 Keyworth av St. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Hardy

(a) RESIDENCE NO. 2807 Keyworth ave ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 9 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A Burke Hardy

6 DATE OF BIRTH (month, day, and year) Oct 31st 1858

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
65	9.	5.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER Wm. H Hardy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York N.Y.

14 Informant Mrs Mary A. Hardy

(Address) 2807 Keyworth ave

15 Filed AUG 6 - 1923 ROBERT R. KRAUTER Burial Permit Recorder

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1 , 1923, to Aug. 5 , 1923, that I last saw him alive on Aug. 3. , 1923 and that death occurred, on the date stated above, at 12.08 a. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Larynx & inanition

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) James L. Askenas M. D.

8-5- 1923 (Address) 4012 Park Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cem DATE OF BURIAL Aug 7 1923

20 UNDERTAKER John F Gowan & Son ADDRESS 901 Hollins

John F Gowan

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78090

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

41 D78090

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vanda ~~Lewandowski~~ LEWANDOWSKI

(a) RESIDENCE NO. 1522 E. Fort St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Joseph Lewandowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: University Hospital Records (Address)

15 Filed AUG 6 1923, 19.... ROBERT R. KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 7 1923

17 I HEREBY CERTIFY, That I attended deceased from July 21, 1923, to August 7, 1923, that I last saw her alive on Aug 4, 1923, and that death occurred, on the date stated above, at 1:15 P.m.

The CAUSE OF DEATH* was as follows:

Extensive Cellulitis of Neck and face.

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) Septicemia (Staphlococcus)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of Aug 4.

Was there an autopsy? No

What test confirmed diagnosis? Microscopic findings

(Signed) B. M. Rhodes M. D.

19.... (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A & C — DATE OF BURIAL: 8-7 1923

20 UNDERTAKER: E. T. Baxter — ADDRESS: 115 E. West St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write legibly. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78091

CERTIFICATE OF DEATH.

33

D78091

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore and Payson Sts

CITY OF BALTIMORE: (No. German Aged Home ST.; WARD)

2-FULL NAME Susannah Clocker no

(a) RESIDENCE. No. German aged Home ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 5 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	9	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St Marys Co (State or country) Md

PARENTS

10 NAME OF FATHER William Clocker

11 BIRTHPLACE OF FATHER (city or town) St Marys Co (State or country) Md

12 MAIDEN NAME OF MOTHER Jeannette Collison

13 BIRTHPLACE OF MOTHER (city or town) St Marys Co (State or country) Md

14 Informant German Aged Home Records (Address) Balto and Payson Sts

15 Filed AUG 6 1923, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1923

17

I HEREBY CERTIFY, That I attended deceased from May, 1923, to Aug. 4th, 1923, that I last saw her alive on Aug 4th, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Tuberculosis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John Hoff, M. D.

8/6, 1923 (Address) 1843 W Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys City Md	Aug 6 1923
20 UNDERTAKER	ADDRESS
Joseph L. B. Cook	1003 W Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DARK

Spec.—1-10-21—M&T—1500 Bks.

165502
D78092

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78092

CERTIFICATE OF DEATH. 16-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Gray.

(a) RESIDENCE NO. 1719 Presbury St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown ds., How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored.

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 17, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baby.

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Francis Gray.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Revina Simmons

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records. (Address)

Filed AUG 6 1923, 19 Robert T. Morrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5 1923

17 I HEREBY CERTIFY, That I attended deceased from August 2, 1923. to August 5, 1923.

that I last saw her alive on August 5, 1923

and that death occurred, on the date stated above, at 7.10 A. m.

The CAUSE OF DEATH* was as follows:

Dysentery (Bacillary)

(duration) yrs. mos 10 da.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? Bacteriological

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS 303

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78093 ✓ D78093

CERTIFICATE OF DEATH.

57

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 N. Stricker ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Diggs

(a) RESIDENCE NO. 1037 N. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Diggs

6 DATE OF BIRTH (month, day, and year) Feb 14 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis (State or country) Maryland

PARENTS

10 NAME OF FATHER King Wm Diggs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Savoy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Annie Diggs (Address) 1032 N Stricker St

15 Filed ....., 19 Robert P. Harrison. Registrar

UGG-1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 — 1923

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1923, to Aug 3, 1923.

that I last saw him alive on Aug 3, 1923,

and that death occurred, on the date stated above, at 9:40 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Marcellus E Jones, M. D.

, 19 (Address) 1745 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glenwood, Md — DATE OF BURIAL 19

20 UNDERTAKER J. A. H. Davis — ADDRESS 1313 Druid

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78094

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78094

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1741 N. Gay Street ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen E. Lemmon

(a) RESIDENCE NO. 1624 N. Gay Street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert C. Lemmon, Jr.

6 DATE OF BIRTH (month, day, and year) June 16, 1904

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
19	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or estshlishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Arthur G. Morhiser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Maryland

12 MAIDEN NAME OF MOTHER Carrie Propf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Maryland

14 Informant Robert C. Lemmon, Jr.

(Address) 1624 N. Gay Street

15 Robert P. Harrison, .19 Registrar

G6-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5, 1923

17

I HEREBY CERTIFY, That I attended deceased from July 15, 1923. to Aug 5, 1923.

that I last saw h[illegible] alive on Aug. 4, 1923.

and that death occurred, on the date stated above, at 5 4 m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Sputum Exam

(Signed) Albert Klingenwall M. D.

8/6 1923 (Address) 613 E. Monument Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Aug. 8 1923

20 UNDERTAKER: Albert L. Hiltz, Jr 1606 — ADDRESS: N. Chester st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Joseph Lenart ✓

D78095

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78095

CERTIFICATE OF DEATH.

X 90

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jos. Lenart.

(a) Residence No. 2340 14th St. N.W. Washington D.C.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1892

7-AGE.	If LESS than 1 day,
31 yrs. ..... mos. ..... ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Water

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Alabama

PARENTS.

10-NAME OF FATHER, Jos. Lenart.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Alabama

12-MAIDEN NAME OF MOTHER, Mary Quire

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Alabama

14- (Informant) Hospital Records

(Address).....

15- AUG 5 1923 192... Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). August 4/23

17- I HEREBY CERTIFY, That I attended deceased from 7/27/23 19... to 8/4/23 19...

that I last saw him alive on 8/4/23 19...

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows: 1

Aortic Insufficiency

Cardiac Decompensation

(Duration) 3 Yrs. yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(Duration) ..... yrs. 1 mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) K. W. Kelley M. D.

, 19 (Address) Mercy

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL, ... 19...
20-UNDERTAKER. Commissioner Health.	ADDRESS AUG 4 - 1923

Robert P. Griffith, Commissioner of Health

UNIVERSITY OF MARYLAND

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D78096

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 V D78096

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital, St. 18 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Smiley

(a) Residence No. 831½ Raborg St. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Black	?

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1878

7-AGE. 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ?

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) ?

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER (city or town) (State or Country).

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant) Municipal Hospital Records

(Address)

15- Filed 192 Registrar.

Robert P. Harrison

UNIVERSITY OF MARYLAND

AUG 4 - 1923

Commissioner Health.

DEC 6 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) August 1, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 25 1923 to August 1 1923

that I last saw him alive on August 1 1923

and that death occurred, on the date stated above, at 11:55 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cerebral Hemorrhage (Right Hemiplegia)

(Duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude S. Thomas M. D

8-2-23 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal**, or **Homicidal**. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. 19

20-UNDERTAKER. ADDRESS

IMPORTANT: Physicians should be extremely careful in filling out this certificate. All blanks should be filled. Exact statement of OCCUPATION is very important. Cause of death should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78097 161-001 D78097

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421 E 23 rd St ST., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Mitchell

(a) RESIDENCE NO. 421 E 23 rd St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
fm	aa	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 20 min.
—	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... no

(b) General nature of industry, business, or establishment in which employed (or employer) ..... no

(c) Name of employer no

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Christopher Dixon

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) unknown

12 MAIDEN NAME OF MOTHER Elizabeth Mitchell

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country) Va

14 Informant Mother Elizabeth Mitchell (Address)

Filed AUG 6 1923 19 Robert F. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1923 to Aug 3, 1923, that I last saw her alive on Aug 3, 1923 and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Premature Birth and Physical condition of Mother—

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Physical condition of Mother (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of no

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Ex.

(Signed) Carl Hall M. D.

19 (Address) 426 E 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health,

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

SWEM

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78098

D78098

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. G. Fred Swem

(a) Residence No. 3007 Guilford Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs G Fred Swem

6-DATE OF BIRTH (month, day and year) Oct. 30 1875

7-AGE.	If LESS than 1 day,
47 yrs. 9 mos. 5 ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... 671

(b) General nature of Industry, business, or establishment in which employed (or employer) Insurance Agent

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, Robert Swem

11-BIRTHPLACE OF FATHER (city or town)..... Md.
(State or Country),

12-MAIDEN NAME OF MOTHER, Mary Walters

13-BIRTHPLACE OF MOTHER (city or town)..... Md.
(State or Country),

14- (Informant) Hospital Records

(Address).....

15- Filed ..... 192 Robert P. Harrison, Registrar.

Burial Permit Issued

66 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 4-1923

17- I HEREBY CERTIFY, That I attended deceased from 8/1/23, 19.. to 8/4/23, 19..

that I last saw h alive on 8/4/23 19..

and that death occurred, on the date stated above, at 11.50 A. m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(Duration) ....yrs. ....mos. 7 ds.

CONTRIBUTORY (Secondary) Peritonitis

(Duration) ....yrs. ....mos. 6 ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of 8/2/23.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H W. Lilly M. D.

, 19 (Address) Mercy

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Ridge	Aug. 7 1923
20-UNDERTAKER.	ADDRESS
Horace A. Burgee	361 Gallo Rd.

Should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78099 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78099

CERTIFICATE OF DEATH.

129 REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 312 S Stricker ST., WARD)

2-FULL NAME Margaret Elwood

(a) RESIDENCE NO. 312 S Stricker ST., 17 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Elwood

6 DATE OF BIRTH (month, day, and year) May 15 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thos Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Duffy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Patrick Elwood (husband)

(Address) 312 S Stricker St

15 Filed Aug 6 1923 Robert F. Barnhart Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4, 1923

17

I HEREBY CERTIFY, That I attended deceased from November 1, 1922 to August 4, 1923.

that I last saw her alive on August 3, 1923.

and that death occurred, on the date stated above, at 2.30 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertension, myocarditis,

Nephritis (Chronic), uremia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs & symptoms

(Signed) Edward Morris, M. D.

Aug 5, 1923 (Address) 1430 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem — DATE OF BURIAL 8/7, 1923

20 UNDERTAKER George W. Farley — ADDRESS Fallston, Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

IG 6-1923

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78100

CERTIFICATE OF DEATH.

113

D78100

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1321 Andre ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Veronica P. Sobotka

(Residence in Baltimore: No. 1321 Andre St.; yrs. 1 mos. 19 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.): Single

6-DATE OF BIRTH: June (Month) 18 (Day), 1922 (Year)

7-AGE, yrs. 1 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work:
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country): Baltimore

PARENTS.

10-NAME OF FATHER: Vincent Sobotka

11-BIRTHPLACE OF FATHER (State or Country): Russian Poland

12-MAIDEN NAME OF MOTHER: Virginia Ivoa

13-BIRTHPLACE OF MOTHER (State or Country): Russian Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Vincent Sobotka

(Address) 1321 Andre St

15-

Filed AUG 6-1923, 191

Robert P. Harrison, Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH: August (Month) 6 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 6 1923, to Aug 6 1923, that I saw h[er] alive on Aug 6th 1923, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Intoxication

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 1/2 ds.

(Signed) [illegible] M. D.

8-6, 1923 (Address) 801 N. Linden Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Farmer or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary — DATE OF BURIAL, August 7, 1923

20-UNDERTAKER John M. Weber — ADDRESS 1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

(Felton)

D78101

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D78101

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 Lemmon ST. 10A WARD)

2-FULL NAME Ida Felton

(a) RESIDENCE No. 1309 Lemmon ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced (or) WIFE of Clarence Felton

6 DATE OF BIRTH (month, day, and year) Sept-10-1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Virginia

PARENTS

10 NAME OF FATHER Henry Spenser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Newborn North Carolina

12 MAIDEN NAME OF MOTHER Ella Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Borton Virginia

14 Informant Ella Spenser (Address) 1309 Lemmon St.

15 Filed ..... 19.. Registrar

AUG 6-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug, 4 1923

17

I HEREBY CERTIFY, That I attended deceased from July, 16, 1923, to Aug, 4, 1923, that I last saw her alive on Aug, 3, 1923, and that death occurred, on the date stated above, at 12, M.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration) — yrs. 3 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no, Date of

Was there an autopsy? no.

What test confirmed diagnosis? none

(Signed) Dunn Franklin M. D.

Aug 6, 1923 (Address) 132 W. Lee St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL Aug 7th 1923

20 UNDERTAKER A. J. Jones — ADDRESS 111 S. Gilmor St

Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

16 5 724
D78102

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78102

CERTIFICATE OF DEATH.

16-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothea Watson.

(a) RESIDENCE NO. 1314 Gilmor ST. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar. 30, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
		4	7.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Watson.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Myrtle Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant

(Address) Records.

15 Filed AUG 6 - 1923, 19.. Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1923. to August 6, 1923.

that I last saw her alive on August 6, 1923.

and that death occurred, on the date stated above, at 6 05 A. m.

The CAUSE OF DEATH* was as follows:

Dysentery (Flexner)

(duration) 0 yrs. 0 mos 15 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia, Otitis Media

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of —

Was there an autopsy? yes.

What test confirmed diagnosis? growth of bacillus Flexner from stools.

(Signed) William H. F. Warthen M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Aug 8th 1923

20 UNDERTAKER: A. Jones — ADDRESS: N. L. Gilmor

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78103

CERTIFICATE OF DEATH.

90

D78103

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 S. Catherine ST.: WARD)

2-FULL NAME Elizabeth Baden

(a) RESIDENCE. No. 107 S. Catherine ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 3 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin Baden

6 DATE OF BIRTH (month, day, and year) April 17 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Conrad H. Bosch

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germ.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germ.

14 Informant Edwin Baden
(Address) 107 S. Catherine St

15 Filed [illegible] 1923 Registrar

GB-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 5th, 1923, to Aug 5th, 1923, that I last saw h[illegible] alive on Aug 3 1923, and that death occurred, on the date stated above, at 6:25 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Valvular Insufficiency with Heart

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Urinary

(Signed) E. Mitchell, M. D.

, 19 (Address) 1106 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	1923
20 UNDERTAKER	ADDRESS
E. Schumacher Son	Pimlico

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78104

CERTIFICATE OF DEATH.

40 D78104

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore Hospital ST., (WARD)

2-FULL NAME Mrs Alma V Perkins

(a) RESIDENCE NO. Orchard ave & 6th St ST., Brooklyn WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matt J. Perkins

6 DATE OF BIRTH (month, day, and year) June 24th 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER David Wroten

11 BIRTHPLACE OF FATHER (city or town) Maryland (State or country)

12 MAIDEN NAME OF MOTHER Martha Leighman

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Matt J Perkins (Address) Orchard ave. Brooklyn

15 AUG 6 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1923, to Aug 4, 1923, that I last saw h[illegible] alive on Aug 4, 1923, and that death occurred, on the date stated above, at 7:25 A m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

Chronic myocarditis

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) acidosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 30, 1923

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. C. Warlick, M. D.

8/4/, 1923 (Address) South Baltimore Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Aug 7 1923
20 UNDERTAKER C. Halmondson	ADDRESS Baltimore

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

D78105

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78105

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 247 N Preston St. 11 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bernard James Fisman

(Residence in Baltimore: No. 247 N Preston St St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED, WIDOWED, OR DIVORCED,~~ Single (*Write* the word.)

6-DATE OF BIRTH, Sept. (Month) 23 (Day) 1884 (Year)

7-AGE, 38 yrs. 10 mos. 12 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): Advertising

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Bernard James Fisman

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary A. Brayden

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Claude D. Fisman

(Address) 2741 N Calvert St

15- [illegible]

Filed ....., 191.... Registrar.

1923 [illegible] Clerk

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 5th (Day), 1913 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Alcoholism

(Duration) ....yrs. ....mos. 8 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ....yrs. ....mos. ....ds.

(Signed) Fred Talbot Blades M. D. (Coroner.)

Aug 5th 1923 (Address) 1436 W Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL, New Cathedral Cem. DATE OF BURIAL, August 7, 1923

20-UNDERTAKER Henry H Jenkins Sons ADDRESS Preston & Collett St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78106 ✓ D78106

CERTIFICATE OF DEATH.

1 90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 Colvin ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Bellistri

(a) RESIDENCE NO. 424 Colvin St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Antonio Bellistri

6 DATE OF BIRTH (month, day, and year) Feb 15 1871

7 AGE: Years 52 yrs | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER Pietro Salamone

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER Carolina D'Pasquale

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant Antonio Bellistri
(Address) 424 Colvin St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1923

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1923, to Aug 5, 1923, that I last saw h[illegible] alive on Aug 5, 1923 and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Bronchitis with pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi D. Di Stefano M. D.

Aug 6 1923 (Address) 407 S. Exeter St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: Aug. 7 1923

20 UNDERTAKER: Geo. J. Ruth — ADDRESS 1735 Hayward Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

066 - 1923

Spec—12-23-21—E.B.R.S.—400 Eks.

D78107

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D78107

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., [illegible] Ward) No

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Whittley

(a) Residence No. Bay View Asylum St., Ward.....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): 1884

7-AGE. 39 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): New Jersey

PARENTS.

10-NAME OF FATHER: unknown?

11-BIRTHPLACE OF FATHER (city or town) (State or Country): ? unknown

12-MAIDEN NAME OF MOTHER: ? unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): ? unknown

14- (Informant) Municipal Hospital Records

(Address)

15- Filed ..... 192... Robert J. Morrison Registrar.

Deputy Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): August 4, 1923

17- I HEREBY CERTIFY, That I attended deceased from May 14 19 23 to August 4 19 23

that I last saw her alive on August 3 19 23

and that death occurred, on the date stated above, at 6:45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. 3 mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Claude B. Dunn M. D

8-4-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Sacred Heart Cemetery	Aug 7 1923
20-UNDERTAKER,	ADDRESS
Geo. F. Rutter	1735 Hartford Ave.

AUG 5 1923

Please be careful, supplies are limited. Write plainly in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

D78108

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78108

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE Hospital Police Station Ward 11

2-FULL NAME John T. Hynes

(Residence in Baltimore: No. 1041 Guilford Ave., St., yrs., mos., ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: July 26th (Month) (Day) 1878 (Year)

7-AGE: 45 yrs. mos. 9 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cooper
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto

PARENTS.

10-NAME OF FATHER: Patrick Hynes

11-BIRTHPLACE OF FATHER, (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Hanora Touley

13-BIRTHPLACE OF MOTHER, (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Patrick Hynes

(Address) 1310 Ensor St

15- AUG 7 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Aug 4 (Month) (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Alcoholism

(Duration) Yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Thrombosis

(Duration) Yrs. mos. 1 ds.

(Signed) Geo. C. Blades M. D. (Coroner.)

(Address) 431 E. Biddle

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: St. Patrick

DATE OF BURIAL: Aug 7 1923

20-UNDERTAKER: Henry C. Wiedefeld

ADDRESS 914 Greenmount Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D78109 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D78109

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2513 Fosterbury St. (WARD) 13

2-FULL NAME Margaret Dichtold

(a) RESIDENCE NO. 2513 Fosterbury St. WARD 13

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Henry Dichtold

6 DATE OF BIRTH (month, day, and year): April 25, 1875

7 AGE: Years 48 Months 4 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Joppa Harford Co Md

PARENTS

10 NAME OF FATHER: Robert H Lowyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Hutter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co Md

14 Informant (Address): Mary Unger Daughter 2513 Fosterbury

15 Filed AUG 7 1923 ROBERT R. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1923, to Aug 3, 1923.

that I last saw h[illegible] alive on Aug 3 1923

and that death occurred, on the date stated above, at 11:50 P. m.

THE CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(duration) 1 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) — yrs 1 mos 2 ds.

18 Where was disease contracted if not at place of death? [illegible] Hospital

Did an operation precede death? Yes Date of Oct 31, 1922

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Rowland M. D.

(Address) 3105 Adeline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Joppa Harford Co Md — DATE OF BURIAL: Aug 6 1923

20 UNDERTAKER: H. Sander Sons — ADDRESS: 1710 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78110

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D78110

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 S. 15th St ST., WARD)

2-FULL NAME Carlena Wilhelmina Hintze

(a) RESIDENCE No. 512 S. 15th St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William C. Hintze

6 DATE OF BIRTH (month, day, and year) Sept 16-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Charles Batine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Katie Baier (Address) 512 S. 15th St.

15 Filed AUG 7 1923 ROBERT A. KRAMER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 1. 1923, to Aug 4 1923.

that I last saw h alive on Aug 3 1923.

and that death occurred, on the date stated above, at 7 20 A m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Franklin Hazlehurst M.D. M. D.

, 19 (Address) 3222 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1st Evangelical Cem	Aug 7 1923
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Eutaw

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D78111

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78111

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

City of BALTIMORE. (No. 108 S. Paca St., Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Constantique Arvanitis

(a) Residence No. 108 S. Paca St. Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Olympia

6-DATE OF BIRTH (month, day and year) Dec 12 1847

7-AGE. 75 yrs. 5 mos. 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook - 21

(b) General nature of Industry, business, or establishment in which employed (or employer) Restaurant

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Turkey

PARENTS.

10-NAME OF FATHER Mich. Arvanitis

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Turkey

12-MAIDEN NAME OF MOTHER. Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Dont Know

11- (Informant) Mich. Arvan

(Address) 108 Paca St South

15- AUG 7 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 5 23.

17- I HEREBY CERTIFY, That I attended deceased from Aug 3 1923 to Aug 5 1923 that I last saw h[illegible] alive on Aug 5 1923 and that death occurred, on the date stated above, at 9 p m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) old age

(Duration) yrs. mos. ds.

18-Where was disease contracted? If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M C Simmons M D

8/6/23 (Address) 628 Washington Blvd

* State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Woodlawn Cem	Aug 7 1923
20-UNDERTAKER. ROBERT BROOKS & SON. FUNERAL DIRECTORS & EMBA	ADDRESS Calhoun & Hollins

Entries to be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Spec.—I-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78112 44 D78112

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 Sylvan Ave ST., Hamilton WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Lewis

(a) RESIDENCE NO. 10 Sylvan Ave ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of John J Louis

6 DATE OF BIRTH (month, day, and year) March 26/867

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
56	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) York Pa
(State or country)

PARENTS

10 NAME OF FATHER Conrad Rembardt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER C. Schmidt

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs John J Louis
(Address) 10 Sylvan Ave

15 Filed AUG 7 - 1923 19 ROBERT R. KRAMER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/4/ 1923

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1923, to Aug 4, 1923

that I last saw her alive on Aug 4, 1923

and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ... yrs. mos ... ds.

CONTRIBUTORY (Secondary) Eclampsia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Symptoms

(Signed) E C Lewis, M. D.

, 19 (Address) 4706 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	Aug 7 1923
20 UNDERTAKER John F Dorsey	ADDRESS 715 E. 5th St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of.....(name origin; for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

Lung

Spec.—1-10-21—M&T—1500 Bks.

D78113 HEALTH DEPARTMENT—CITY OF BALTIMORE D78113

CERTIFICATE OF DEATH. 162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Dr. Balto Gen. Hosp. WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby maranitz

(a) RESIDENCE NO. 212 So. Chas St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
				4 hrs 30 mm

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto - md -
(State or country)

PARENTS

10 NAME OF FATHER Louis Maranitz

11 BIRTHPLACE OF FATHER (city or town) Balto -
(State or country) md -

12 MAIDEN NAME OF MOTHER Marguite Rudolph

13 BIRTHPLACE OF MOTHER (city or town) Vermont
(State or country) md -

14 Informant Louis Markowitz
(Address) 212 S Charles

15 AUG 7 1923 ROBERT R. KRAUTER Registrar
Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1923

17 I HEREBY CERTIFY, That I attended deceased from 6:30 pm. 8/5. 1923. to 11:00 pm. 1923.
that I last saw him alive on Aug 5 , 1923.
and that death occurred, on the date stated above, at 11:00 pm.
The CAUSE OF DEATH* was as follows:
Atelectasis

(duration) 4 hrs - 30 mm yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....
Did an operation precede death?..... Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) H. G. Warfield, M. D.
8/6 1923 (Address) South Balto Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Cedar Hill Cem. DATE OF BURIAL: Aug 7, 1923

20 UNDERTAKER: A. Howard Evans ADDRESS: 1428 E Chas

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78114

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78114

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 22 E 25th St ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Taylor

(a) RESIDENCE NO. 22 E 25th. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Adams Taylor

6 DATE OF BIRTH (month, day, and year) Jan 22 28

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	95	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bank

(b) General nature of Industry, business, or establishment in which employed (or employer) Watchman

(c) Name of employer Eutaw Bank

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Samuel Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Hartz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mandi E Taylor

(Address) 22 E 25th St

15 Filed ..... 19 ..... Registrar

AUG 7 1923 Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 2 1923 to Aug 4 1923, that I last saw him alive on Aug 3 1923, and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis and Asthenia Senilis

(duration) Some 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Sudden Pulmonary Oedema (duration) — yrs. — mos. 1½ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Examination

(Signed) Robert W. Mefflin, M. D.

8/4, 1923 (Address) No 1016 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Parkcem	Aug 7 1923
20 UNDERTAKER	ADDRESS
W M Routson	2236 N Monta

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78115

CERTIFICATE OF DEATH. 74-002 D78115

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 26 Batavia ave ST.: WARD)

2-FULL NAME Emily J Smith

(a) RESIDENCE. NO. 26 Batavia ave ST., WARD

(Usual place of abode) (If not resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of C. B. Smith

6 DATE OF BIRTH (month, day, and year) Dec 25 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Lennox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Bauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant C B Smith (Address) 26 Batavia

15 Filed. ROBERT A. KRAUSE Registrar Burial Permit Clerk AUG 7 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1923

17 I HEREBY CERTIFY, That I attended deceased from July 15 1923, to Aug 5 1923

that I last saw h as alive on Aug 5 1923

and that death occurred, on the date stated above, at 8 8. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo L Ong, M. D.

8/6. 1923 (Address) 27 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 8 1923
20 UNDERTAKER	ADDRESS
W. M. Rowlson	2230 N Smith

AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78116

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78116

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2425 Lakeview Ave.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abram E. Strauss

(a) RESIDENCE NO. 2425 Lakeview Ave.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maymie Strauss

6 DATE OF BIRTH (month, day, and year): Feby. 27 1857

7 AGE — Years: 66 — Months: 5 — Days: 9 — If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Cigar Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond, Va.

PARENTS

10 NAME OF FATHER: Emanuel Strauss

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Fannie Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr. Sylvan Strauss
(Address) 2425 Lakeview

15 Filed AUG 7 1923 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/6/1923

17 I HEREBY CERTIFY, That I attended deceased from May-18, 1923, to Aug.-6, 1923, that I last saw him alive on Aug.-6, 1923, and that death occurred, on the date stated above, at 12.40 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy- followed by —
Myocardial- insufficiency.

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chronic-Nephritis-Hypertension
Arteriosclerosis (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? - Urinary Casts -

(Signed) Joseph William Kelly M. D.

19 (Address) 910-Brooks Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Richmond, Va.

DATE OF BURIAL: 8/9/1923

20 UNDERTAKER: David Sondheim

ADDRESS: 118-20 W. Mt. Royal Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78117 ✓ D78117

CERTIFICATE OF DEATH.

112

REGISTERED NO.

1-PLACE OF DEATH 1529. Ramsey.

CITY OF BALTIMORE: (No. ~~Charles H. Shipley~~ ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~1529~~ Charles H. Shipley

(a) RESIDENCE No. 1529 Ramsey St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Shipley

6 DATE OF BIRTH (month, day, and year) 1839.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 075

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joshua Shipley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lennie Ireland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John A Shipley
(Address) 1529 Ramsey St

15 Filed AUG 1923 19 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1923.

17 I HEREBY CERTIFY, That I attended deceased from August 2, 1923, to August 5, 1923, that I last saw him alive on August 5, 1923, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction
(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Old age
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Abdominal Pain

(Signed) S. J. Sinclair M. D.

1923 (Address) 1511 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 8 1923
20 UNDERTAKER	ADDRESS
Wm Cook & Son E Baltimore	

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78118

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78118

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., WARD) N

2-FULL NAME Mrs. Katherine Rice

(a) RESIDENCE NO. 1140 Washington Boulevard ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Aug 2 1851

7 AGE Years 72 Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Rice

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Kane

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Ireland

14 Informant W B Rice

(Address) 1140 Washington Boulevard

15 Filed AUG 7 1923 ROBERT A. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 2nd, 1923, to Aug. 5th, 1923, that I last saw her alive on Aug. 5th, 1923, and that death occurred, on the date stated above, at 8:15 A.M.

The CAUSE OF DEATH* was as follows:

Acute appendicitis Intestinal obstruction, paralytic ileus.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of Aug. 5

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings.

(Signed) James D. Heath M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Aug 8 1923

20 UNDERTAKER John J. Fields ADDRESS 1200 W Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D78119 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78119

CERTIFICATE OF DEATH. 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 324 Pine St ST. 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or Institution, give its NAME Instead of street and number and fill out No. 18.)

2-FULL NAME Johnn Lindsey

(a) RESIDENCE NO. 324 Pinn ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or Divorced (write the word)
male	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) may 4. 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work infent
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore city md
(State or country)

PARENTS

10 NAME OF FATHER Charles Lindsey

11 BIRTHPLACE OF FATHER (city or town) md
(State or country)

12 MAIDEN NAME OF MOTHER irvoy washington

13 BIRTHPLACE OF MOTHER (city or town) md
(State or country)

14 Informant irvoy washington
(Address) 324 pin st

15 Filed AUG 7 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... ~~(Inquest, autopsy or inquiry.)~~ find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tooth Enfection

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary) Mal Practice

(duration) ... yrs. ... mos. 7 ds.

(Signed) H. A. Geo[illegible], M. D.
(Coroner.)

8-6- 1923 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cemetery	Aug 7-1923
20 UNDERTAKER Edward Bryan	ADDRESS 661 Orleans st

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78120

CERTIFICATE OF DEATH.

D78120

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. 8. Monument — ST.: — WARD) 13

2-FULL NAME Simon Penn

(a) RESIDENCE. NO. 2477 Druid Hill Ave. ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel Penn

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Lait Penn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Ethel Penn
(Address) 2477 Druid Hill Ave

15 Filed . 19 ROBERT R. [illegible]
AUG 7 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/6 1923

17

I HEREBY CERTIFY, That I attended deceased from August 4 . 1923 . to August 6 . 1923 .

that I last saw h alive on Aug 6 . 19 .

and that death occurred, on the date stated above, at 9 02 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Appendicial Abscess

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of August 4, 1923

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A Stolz Sondheimer, M. D.

8/7. 1923 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Workmen Circle	8/7 1923

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78121

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

170 ✓ D78121

Registered No. C.....

1-PLACE OF DEATH: Johns Hopkins Hospital

City of BALTIMORE: (No. ~~137 Jackson Place~~ St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: Frank ~~Weiner~~ Weiner

(Residence in Baltimore: No. 137 Jackson Place St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced. (Write the Word.)
male	white	married

6-DATE OF BIRTH, ..unknown.. (Month) (Day) 1896 (Year)

7-AGE, 27 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Printer
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Pocomoke City Md.

PARENTS.

10-NAME OF FATHER, Michael David Weiner

11-BIRTHPLACE OF FATHER, (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Rebecca Schahet

13-BIRTHPLACE OF MOTHER, (State or Country), Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) David Abrahams

(Address) 4606 Towanda Ave

15- AUG 7 - 1923 ROBERT R. KRAUTER Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 6/23 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide- Pistol shot thru rt. temple.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) J S Hollman M. D. (Coroner.)

8/7/23 192 (Address) 508 E. North Ave

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Rodelph DATE OF BURIAL, Aug 7th 1923

20-UNDERTAKER, Jack Levin ADDRESS 1437 E. Balto

I. S. Copy. Each information should be carefully supplied, as state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D78122

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78122

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St Joseph Hosp., WARD) 16

2-FULL NAME Charles Texeria

(a) RESIDENCE NO. 1136 Mosher St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	12	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md

PARENTS

10 NAME OF FATHER Antone Texeria

11 BIRTHPLACE OF FATHER (city or town) (State or country) Portugal

12 MAIDEN NAME OF MOTHER Sadie Brooke

13 BIRTHPLACE OF MOTHER (city or town) St (State or country) Mary's County Md

14 Informant Antone Texeria

(Address) 1136 Mosher St

15 Filed ..... 19 ..... ROBERT R. KRAUTER Registrar

Bureau Records Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4th 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 3rd 1923 to Aug 4th 1923, that I last saw him alive on Aug 4th 1923, and that death occurred, on the date stated above, at 9:45P m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) Acute appendicitis

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 8-3-23

Was there an autopsy? No.

What test confirmed diagnosis? Oper.

(Signed) Dr H Pillsbury, M. D.

, 19 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peter's Cemetery	Aug 8 1923
20 UNDERTAKER	ADDRESS
Mrs Chas L. Bailey	1421 Jefferson St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78123

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78123

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt. Hope Retreat ST.: 28 (WARD) 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Shannessy. D78

(a) RESIDENCE. NO. Mt. Hope Retreat ST., WARD. (Resident)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 20 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 57 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Unknown Maryland.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mt. Hope Retreat (Address)

15 Filed AUG 7 1923 19 ROBERT A. KRANTZ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Sudden death, 19..., to ..., 19..., that I last saw h. im alive on Aug 7, 1923, and that death occurred, on the date stated above, at 5.9 a.m.

The CAUSE OF DEATH* was as follows:

Fatty degeneration and acute dilatation of Heart

Sudden death

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Manic Depressive Psychosis

(duration) 25 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None Except Usual

(Signed) Milton P. Hill, M. D.

, 19 (Address) Hyliard & Reduton Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery Co

DATE OF BURIAL Aug- 8 1923

20 UNDERTAKER STEWART & MOWER [illegible]

ADDRESS 108 W. NORTH AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78124

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. D78124

1-PLACE OF DEATH
City of BALTIMORE: (No. 500 Dolphin St. 11 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Amelia Hancock
(Residence in Baltimore: No. 500 Dolphin St.; yrs. 40 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE SHOULD BE STATED EXACTLY. Prefixes or titles may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female
4-COLOR OR RACE: Colored
5-Single, Married, Widowed or Divorced (Write the word.): Widow
6-DATE OF BIRTH: August 1868 (Month) (Day) (Year)
7-AGE: About 55 yrs. mos. ds. If LESS than 1 day, hrs. or min.?
8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
9-BIRTHPLACE (State or Country): Washington D. C.

PARENTS:
10-NAME OF FATHER: Eugene Thurson
11-BIRTHPLACE OF FATHER (State or Country): Va
12-MAIDEN NAME OF MOTHER: Francis Letts
13-BIRTHPLACE OF MOTHER (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Mrs Eugene Thurson
(Address): 500 Dolphin St

15- Filed AUG 7 - 1923 ROBERT B. KRAUTER, Registrar.
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Aug 3 23 (Month) (Day) (Year)
17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and from autopsy (or inquiry.) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows: Mitral Stenosis
(Duration) yrs. 0 mos. 14 ds.
CONTRIBUTORY (Secondary) Pneumonia
(Duration) yrs. mos. ds.
(Signed) G. C. Bowles M. D.
(Coroner) 192 (Address) 453 N. Eutaw
*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Washington D.C. DATE OF BURIAL: Aug 7 1923
20-UNDERTAKER: Samuel Handy ADDRESS 1328 W Baltimore

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78125 90 D78125

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St Joseph Hosp., WARD) 17

2-FULL NAME James Fuqua

(a) RESIDENCE NO. 518 N. Dolphin St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	mar.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Esty Fuqua

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
53	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) Va.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Hester Fuqua.
(Address) 518 Dolphin St.

15 AUG 7 - 1923 19 ROBERT N. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1923

17

I HEREBY CERTIFY, That I attended deceased from May 2, 1923, to Aug 4, 1923, that I last saw him alive on Aug 4th, 1923 and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation.

(duration) yrs. 6 mos. 3 ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) 2 yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) H. Pillsbury, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	Aug 7 1923
20 UNDERTAKER Samuel S Hawley	ADDRESS Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ODAK

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78126

D78126

CERTIFICATE OF DEATH.

#7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1224 E. Chase St. ST., 10 WARD)

2-FULL NAME Margaret. A. Peters

(a) RESIDENCE NO. 1224 E. Chase St. ST., 10 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

10

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) ~~WIFE~~ of John. J. Peters

6 DATE OF BIRTH (month, day, and year) Feb.-18-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60.	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER Philip Fladung

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mr. John. J. Peters

(Address) 1224 E. Chase St

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug.-6-1923

17 I HEREBY CERTIFY, That I attended deceased from May 8th, 1923, to Aug 6th, 1923. that I last saw her alive on July 31st, 1923. and that death occurred, on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Adenocarcinoma

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nasopharynx

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S. H. Stokes, M. D.

Aug 8th 1923 (Address) 1501 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Aug. 9 1923

20 UNDERTAKER Henry Hoeck & Son — ADDRESS 1301 E Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

165504, D78127

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78127

CERTIFICATE OF DEATH. X16-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Raley

(a) RESIDENCE No. 661 Maryland Ave ST., Washington, D.C. WARD)

(Usual place of abode)

Length of residence in city or town where death occurred mos. Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Regina (mother),

6 DATE OF BIRTH (month, day, and year) Jan. 21, 1923

7 AGE: Years — Months 6 Days 16 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of Industry, business, or establishment in which employed (or employer): (H)

(c) Name of employer: (H)

9 BIRTHPLACE (city or town) (State or country): N.Y.

PARENTS

10 NAME OF FATHER Jay Mare

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER Regina Robrecht.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Records

15 Filed AUG 7 - 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1923, to Aug 6, 1923, that I last saw him alive on Aug 6, 1923, and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Dysentery (bacillary)
Type not known

(duration) yrs. mos 5 ds. +

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?.....

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) A. G. Mead, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. (Lwg.) | DATE OF BURIAL: 1923

20 UNDERTAKER: Martin Fraley | ADDRESS: 662 W. Mulberry

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78128 HEALTH DEPARTMENT—CITY OF BALTIMORE D78128.

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1517 Battery Ave ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret P Plunkett

(a) RESIDENCE NO. 1517 Battery Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Thos. Plunkett

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 84				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boston, Mass.

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) Don't Know (State or country)

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) Don't Know (State or country)

14 Informant Rev. J. F. Whelan

(Address) 1410 Riverside ave.

15 Filed AUG 7 1923, 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 4, 1923. to Aug 6, 1923

that I last saw her alive on Aug 6, 1923

and that death occurred, on the date stated above, at 6.55A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Chronic Nephritis

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Physical Exam

(Signed) J. Edward Jones, M. D.

8/7/23 (Address) 1430 Riverside Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL Aug 8 1923

20 UNDERTAKER Margaret D. Flynn

ADDRESS 1722 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M.S.T.—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78129

CERTIFICATE OF DEATH.

D78129 Preston Hospital

129

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1309 E. Biddle ST.) (WARD) 10

2-FULL NAME Ella E Kelley

(a) RESIDENCE NO. 1309 E Biddle ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward F Kelley

6 DATE OF BIRTH (month, day, and year) July 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER J. Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Edw. Kelley
(Address) 1309 E. Biddle St.

Filed ..... AUG 7 - 1923 ..... 19 ..... Registrar

JEFF. R. KRAUTER, Vital Records Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1923, to Aug. 5, 1923.

That I last saw h.. alive on Aug. 5, 1923.

and that death occurred, on the date stated above, at 12 00 a m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) J. F. Magruder M. D.

Aug 6 1923 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	8/7/1923

20 UNDERTAKER E. J. Fanning - Dec - 1938 E. Lafayette — ADDRESS

CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78130

D78130

CERTIFICATE OF DEATH.

332

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hosp. ST., (WARD) NA

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Pauline Beall.

(a) RESIDENCE NO. 3402 Wilkens Ave. Balt. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 28, 1917

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
6 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Eugene Beall.

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sallie A. Bailey

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Maryland

14 Informant Eugene E Beall

(Address) 3402 Wilkens Ave

AUG 7 1923 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1923, to Aug. 5, 1923, that I last saw her alive on Aug. 5, 1923, and that death occurred, on the date stated above, at 10.25 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis, probably tubercular.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Alexander Novey, M. D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Aug 8 1923
20 UNDERTAKER	ADDRESS
George J Smith	1532 Walbrook

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78131

CERTIFICATE OF DEATH

100-001 D78131

1-PLACE OF DEATH Bayview Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME Annie Stefanski

(a) RESIDENCE NO. 1736 Aliceanna ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Lawrence Stefanski

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) Bayview Hospital Med. Bd.

AUG 7 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 6. 1923

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1923 to Aug 6, 1923
that I last saw h[er] alive on Aug 5, 1923
and that death occurred, on the date stated above, at 2.30 p. m.
The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia (Terminal)

(duration) ..... yrs. ..... mos 1. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Psychosis ?

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No Clinical findings

What test confirmed diagnosis? .....

(Signed) H. F. Schmidt, M. D.

, 19 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.,	Aug. 8th 1923
20 UNDERTAKER	ADDRESS
M. F. Sadowski.	905 S. Ann St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78132

CERTIFICATE OF DEATH.

100-001 D78132

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Kirby

19

(a) RESIDENCE No. 1826 Dover St. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) July 21 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Walter King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co., Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co., Md.

14 Informant Municipal Hospital Records. (Address)

15 Filed AUG 7 - 1923 ROBERT A. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 5 19 23

17

I HEREBY CERTIFY, That I attended deceased from March 1 , 19 23 to August 5 , 19 23, that I last saw h et alive on August 5 , 19 23, and that death occurred, on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (duration) yrs. mos. 5 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Chas. A. Ward, M. D.

8-6- 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old Potters Field

DATE OF BURIAL Aug 8 1923

20 UNDERTAKER [illegible] & SON, N. S. FINK, FUNERAL DIRECTORS, 1006 W. PRATT STREET.

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

165525 D78133

HEALTH DEPARTMENT—CITY OF BALTIMORE D78133

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 18 WARD)

2-FULL NAME Mary Hammond Reed

(a) RESIDENCE NO. 860 Ralsong St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. unknown ds., How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored.	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 4, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife.

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Richard Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lethie Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 AUG 7 1923 ROBERT K. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from August 2 .1923. to August 6, .1923.

that I last saw her alive on August 6, .1923.

and that death occurred, on the date stated above, at 6 05 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.
Cardiac enlargement.

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Pulmonary embolism.

(duration) yrs. mos. last 14 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Chas. W. Cummings M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Furnace Branch Md.

DATE OF BURIAL Aug 8 1923

20 UNDERTAKER Jno. Crow Hall

ADDRESS 845 Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78134

D78134

CERTIFICATE OF DEATH.

113

Registered No.....

PLACE OF DEATH

City of BALTIMORE: (No.) 527 N. Lafayette Court (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Clarence H. Dudley

(a) Residence No. 527 N. Lafayette St., (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Nov. 21, 1922

7-AGE. 8 yrs. 8 mos. 15 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore

(State or Country), Md.

PARENTS.

10-NAME OF FATHER, Julius Dudley

11-BIRTHPLACE OF FATHER (city or town) North Carolina

(State or Country),

12-MAIDEN NAME OF MOTHER Arlean Scott

13-BIRTHPLACE OF MOTHER (city or town) Maryland

(State or Country),

14-

(Informant) Julius Dudley

(Address) 527 Lafayette Ave.

15-

Filed AUG 7 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 5, 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug 3, 1923, to Aug 5 1923

that I last saw h.. alive on Aug 5 1923

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows: Gastro-enteritis

(Duration) 1 yrs. 5 mos. 5 ds.

CONTRIBUTORY (Secondary) Heat exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) R. Garland Mundell M. D.

Aug 6, 1923 (Address) 1534 - 20 St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. McAuley Aug 8 DATE OF BURIAL, 1923

20-UNDERTAKER George D. Gibson ADDRESS Fairmont 673

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78135

CERTIFICATE OF DEATH.

D78135

PLACE OF DEATH Christ's Institution Hospital 74-001 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 704 Eutaw ST., WARD)

2-FULL NAME Emma L. Lewis

(a) RESIDENCE No. 503 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1—1881

7 AGE 42 Years 2 Months 3 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Maid 870

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Samuel Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Maria Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Luther Lewis

(Address) 503 Gilmor st

AUG 7 1923

Filed ..... 19.... ROBERT A. KRAMER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 29, 1923, to August 4, 1923, that I last saw her alive on August 4, 1923, and that death occurred, on the date stated above, at 10.55 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy

Paralysis + Complication

Disease. (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Paralysis + Comp Cicatrix Disease (duration) yrs. 2 mos. 6 ds.

18 Where was disease contracted if not at place of death? 503 Gilmor St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr. G. W. Kennard, M. D.

8-4, 1923 (Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem | DATE OF BURIAL 8/6/23

20 UNDERTAKER Geo. T. A. Gibson | ADDRESS Fairmont 503

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D78136

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78136

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
City of BALTIMORE: (No. Harry Maxwell St., Ward 10)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Augusta Apr. 7

(Residence in Baltimore: No. 7 Augusta Ave. St.; yrs. 57 mos. 1 ds. 0)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): married

6-DATE OF BIRTH: July 6th (Month) (Day) 1866 (Year)

7-AGE: 57 yrs. 1 mos. 0 ds. If LESS than 1 day ....hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Blacksmith
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto Md.

PARENTS.

10-NAME OF FATHER: Thos Maxwell

11-BIRTHPLACE OF FATHER, (State or Country): Ireland

12-MAIDEN NAME OF MOTHER: Mary Markus

13-BIRTHPLACE OF MOTHER, (State or Country): Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary A Maxwell

(Address) 7 Augusta Ave

15- AUG 7 - 1923 ROBERT R. KRAEMER Burial Permit Clerk

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 6 (Month) (Day) 23 (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide Hanging
an Ellar

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. Leon Gaba M. D.
(Coroner.)

192.... (Address) 113 N Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: New Cathedral Cem. DATE OF BURIAL: Aug 8 '23

20-UNDERTAKER: John J Leavan & Son ADDRESS: 901 W Lanvale St

R. 8.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78137

CERTIFICATE OF DEATH.

10 D78137

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2646 Bulaney ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eva Engelke

(a) RESIDENCE. No. 2646 Bulaney ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1921.

7 AGE: Years 2 Months 5 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Lee Puepke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Eliza Pennington

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant Eliza Puepke
(Address) 2646 Bulaney St.

15 Filed AUG 7 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/6/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 8/2/23, 19, to 8/6/23, 19 23
that I last saw h alive on 8/6/23, 19, and that death occurred, on the date stated above, at 1.05 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Heart Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leland Dranin, M. D.

, 19 (Address) 1517 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Aug 7, 1923

20 UNDERTAKER: C. W. Dill

ADDRESS 3109 Frederick Ave

Burial Permit Clerk.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D78138

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

33 D78138

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 824 Parrish ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Ruggold (Mason)

(a) RESIDENCE NO. 824 Parrish ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Mason

6 DATE OF BIRTH (month, day, and year) Oct 28 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	20	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER John Ruggold

11 BIRTHPLACE OF FATHER (city or town) Maryland

(State or country)

12 MAIDEN NAME OF MOTHER Sadie Gross dec'd

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Sadie Ruggold

(Address) 824 Parrish St.

15 Filed AUG 7 - 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 4 1923

17 I HEREBY CERTIFY, That I attended deceased from July 22 1923 to Aug 4 1923

that I last saw h[illegible] alive on Aug 4 1923

and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Tuberculosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Charles E. Clark M. D.

19 (Address) 1306 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: M. Antyne — DATE OF BURIAL: Aug 7 1923

20 UNDERTAKER: Sam M. Casselberry — ADDRESS: 1460 Mosher

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78139

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

D78139

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. General Hospital ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth E Ripley

(a) RESIDENCE No. 2704 Presbury ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 16-1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lewistown Va

PARENTS

10 NAME OF FATHER Guy C Ripley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sallie Boggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Guy C Ripley (Address) 2704 Presbury St

15 Filed AUG 7 - 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1923.

17 I HEREBY CERTIFY, That I attended deceased from August 5. 1923. to August 6. 1923.

that I last saw her alive on August 6. 1923.

and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic toxemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urinalysis

(Signed) Walter H. Tilley M.D.

8/6. 1923. (Address) Md. General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL Aug 8 19 23

20 UNDERTAKER Veteran Co

ADDRESS 120 N Eutaw St

THIS IS A PERMANENT RECORD. Every ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78140 ✓ 187-007 78140

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mercy Hospital ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles R. Kalbskopf

(Residence in Baltimore: No. 1830 E. Biddle St.

St.: yrs. 4/ mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. June (Month) 16 (Day), 1905 (Year)

7-AGE. 18 yrs. 1 mos. 11 da.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Machine Hand
(b) General nature of industry, business, or establishment in which employed (or employer). Lafayette Mill Co

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, William Kalbskopf

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Minnie Fetsch

13-BIRTHPLACE OF MOTHER (State or Country) Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Russ W. Kalbskopf

(Address) 1830 E. Biddle St

15-

Filed ..... 191.....

Registrar.

AUG 1923 OTTO R. KRAUTER Chief Bureau of Vital Statistics

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 6 (Day), 1913 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pott's Fracture

accident

(Duration) yrs. mos. 2 da.

Exhaustion

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. 1 da.

(Signed) G. E. Wades M. D.

(Coroner)

Aug 6 1913 (Address) 943 N. Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....da. In the State.....yrs.....mos.....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Baltimore Cemetery

DATE OF BURIAL, Aug 10 1923

20-UNDERTAKER Jas C. Miller

ADDRESS 2334 Jefferson

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78141 — 45 — D78141

1-PLACE OF DEATH Church Home & Infirmary

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... St., 7 Ward)

2-FULL NAME Catharine Hellmeyer

(a) RESIDENCE No. 1905 Ashland Ave — St. ..... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Henry Hellmeyer.

6 DATE OF BIRTH (month, day, and year) Jan 6 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home nurse

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Chas Muldon

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Hanah Winters

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Henry Hellmeyer
(Address) 1905 Ashland Ave

15 Filed AUG 7 1923 .19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6 1923

17 I HEREBY CERTIFY, That I attended deceased from August 1 1923 to August 6 1923, that I last saw her alive on August 6 1923 and that death occurred, on the date stated above, at 2:45 a m

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

(duration) 1 yrs. (?) mos ds.

CONTRIBUTORY (Secondary) Generalized Peritonitis

(duration) — yrs. — mos. 10 ds. (?)

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? Yes Date of Aug. 1, 1923

Was there an autopsy? .....

What test confirmed diagnosis? Exploratory Operation

(Signed) Reid and G. Cobey M. D.

(Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL Aug 8 1923

20 UNDERTAKER Wm. T. Hartley — ADDRESS 813 N Wash

AUG 7 1923 JOSEPH R. KNAUER Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78142

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78142

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton Walter

(a) RESIDENCE. NO. 4th an + 2nd st Fairfield ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
35	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Maryland Dry Dock. Blackstone Va

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address)

15 Filed ..... 19 ..... Registrar

AUG 7 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/6/23 19

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923, to Aug 6, 1923, that I last saw him alive on Aug 6, 1923, and that death occurred, on the date stated above, at 3:05 P. m.

The CAUSE OF DEATH* was as follows:

Acute Suppurative Appendicitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 4th an + 2nd st Fairfield

Did an operation precede death? Yes Date of Aug 2, 1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Marcellus E Tong, M. D.

, 19 (Address) 1475 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	19
20 UNDERTAKER	ADDRESS

AUG 7 - 1923

...ration should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78143

HEALTH DEPARTMENT—CITY OF BALTIMORE

185 D78143

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Banz (Dany)

(a) RESIDENCE No. 1931 Belair Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Feb 24 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Hain

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Rode

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Germany

14 Informant Municipal Hospital Records.

(Address)

15 Filed AUG 7 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6 1923

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1923, to August 6, 1923

that I last saw her alive on August 5, 1923

and that death occurred, on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:

Fracture neck of right femur

(over)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senility - Bronchitis

arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of -

Was there an autopsy? Yes -

What test confirmed diagnosis? Autopsy

(Signed) Anthony V. Bukhres - M. D.

8-6-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Aug 8 1923

20 UNDERTAKER Robt L Turner Inc — ADDRESS 1401 E Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS would state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DECEPTION is very important. See instructions on back of certificates.

D78144

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78144

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. So. Hotel Right or. 24 St., X90 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 13.)

2-FULL NAME John G. Rust

(Residence in Baltimore: No. Mount Joy Pa St.; yrs. ..... mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
M.	W	Married

6-DATE OF BIRTH: Not known (Month) (Day) (Year)

7-AGE: 66 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of Industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE, (State or Country): Pa.

PARENTS.

10-NAME OF FATHER, Not known

11-BIRTHPLACE OF FATHER, (State or Country), "

12-MAIDEN NAME OF MOTHER, "

13-BIRTHPLACE OF MOTHER, (State or Country), "

14-THE ABOVE IS GIVEN TO THE BEST OF MY KNOWLEDGE.

(Informant) Roy Shadz.

(Address) Mt Joy Pa.

15- Filed AUG 7 1923, 192.....

Robert P. Harrison, Vital Records Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 7 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Bright Compensation

(Duration) Yrs. ..... mos. ..... ds.

(Signed) Geo. Edison Bladen M. D.

(Coroner)

Aug 7 1923 (Address) 1431 E Bray

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs. .....mos. .....ds. In the State.....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Mt Joy Pa.

19-PLACE OF BURIAL OR REMOVAL: Mt Joy Pa. DATE OF BURIAL: Aug 7 1923,

20-UNDERTAKER: John A Wolan ADDRESS 3000 E Baltimore St,

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78145

CERTIFICATE OF DEATH.

90 D78145

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2414 Eager Place ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth T. Berger

(a) RESIDENCE. NO. 2414 Eager Place ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John S. Berger

6 DATE OF BIRTH (month, day, and year) Oct 18 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Frederick Boeddeker (Address) 2414 Eager St.

15 Filed AUG 7 - 1923 Robert R. Harrison Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5 1923

17 I HEREBY CERTIFY, That I attended deceased from 6-1 1923 to 8-5 1923

that I last saw him alive on 8-5 1923

and that death occurred, on the date stated above, at 6 01 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Auto Cardiac Nephritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Indiana

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J. Fred Ruzicka M. D.

6, 1923 (Address) 200 N Patt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Aug 8 1923

20 UNDERTAKER Isaac Cracken

ADDRESS 1906 Gold

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill it may be properly classified. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D78146

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78146

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH: On Steamer O. S. Ford

City of BALTIMORE: (No. Pier 4 Light St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME: John Henry Gardner

(Residence in Baltimore: No. 2008 Eastwood Ave St.; yrs. 60 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH: Dec 12 (Month) (Day) 1858 (Year)

7-AGE: 64 yrs. 8 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Marine
(b) General nature of industry, business, or establishment in which employed (or employer): Engineer

9-BIRTHPLACE, (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: Lard Gardner

11-BIRTHPLACE OF FATHER, (State or Country): Indiana

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country):

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Gardner

(Address) 2008 Eastwood Ave

15-

Filed AUG 7-1923 Robert F. Carrington Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 7 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound

Suicide

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Shock

(Duration) 1 yrs. ....mos. ....ds.

(Signed) Geo. Austin Bladen M. D.

(Coroner.)

Aug 7/23 (Address) 142 N. Bond

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Loudon Park DATE OF BURIAL, ..., 19....

20-UNDERTAKER, H. Tickner & Son ADDRESS Park Ave

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN's should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—I-10-21—M&T—1500 Bks.

D78147

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78147

CERTIFICATE OF DEATH.

REGISTERED NO. 146

1-PLACE OF DEATH Maryland, University Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 20 WARD)

2-FULL NAME Mrs. Edith E. Hildebrand

(a) RESIDENCE NO. 302 N. Fulton ST., 20 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 7 mos. 11 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	white.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. William A. Hildebrand

6 DATE OF BIRTH (month, day, and year) Dec 25-1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	27	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER George Auta.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. William E. Hildebrand (Address) (University Hosp. Records)

15 Filed ..... 19 ..... Registrar Robert P. Garrison, Burial Permits Clerk

AUG 7 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/5 1923.

17 I HEREBY CERTIFY, That I attended deceased from 7/25, 1923, to 8/5, 1923, that I last saw h er alive on 8/5, 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia, following child birth
Suppurative endometritis
& Ovarian abscess, left.

(duration) — yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia, lung abscess (duration) — yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? 302 N. Fulton St.

Did an operation precede death? Delivery Date of July 15, 1923.

Was there an autopsy? Yes.

What test confirmed diagnosis? Inspection.

(Signed) Ralph D. Hagner, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL Aug 7, 1923

20 UNDERTAKER F. A. Weipert ADDRESS 2216 Fred'k Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78148

CERTIFICATE OF DEATH.

90 D78148

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3305 E Baltimore ST. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ludwig H Lettow

(a) RESIDENCE. No. 3305 E Baltimore ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Lettow

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	—	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Carl Lettow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Katherine Lettow (Address) 3305 E Baltimore st

15 Filed ..., 19... Registrar

AUG 7 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-5- 1923

17 I HEREBY CERTIFY, That I attended deceased from [illegible]-, 1923, to Aug 5, 1923, that I last saw h[illegible] alive on Aug-4, 1923, and that death occurred, on the date stated above, at 5.20 a m.

The CAUSE OF DEATH* was as follows:

Valvular Dis. Heart-

1 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ven Rectal Abscess

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of July. 10/23

Was there an autopsy? no

What test confirmed diagnosis? ...

(Signed) Dr. A. Brunet, M. D.

, 19 (Address) 1258 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emanuel Cemetery	aug 8 1923

20 UNDERTAKER Geo M Fink & Son ADDRESS 811 N Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78149 — CERTIFICATE OF DEATH. — X155 — D78149

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen Hospy ST., 11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Chas M. Casto

(a) RESIDENCE No. 514 Park Ave ST., WARD .....

(Usual place of abode) of Buckhannon W Va

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1, 1905

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
18	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Paul
(State or country) Minn

PARENTS

10 NAME OF FATHER L. F. Casto

11 BIRTHPLACE OF FATHER (city or town) Lorentz
(State or country) W. Va.

12 MAIDEN NAME OF MOTHER Alma Johnson

13 BIRTHPLACE OF MOTHER (city or town) Sundag
(State or country) Minn

14 Informant Mr. L. F. Casto
(Address) R. F. D. No. 1 Buckhannon W. Va

15 Filed AUG 8 - 1923 ROBERT A. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-7-23

17 I HEREBY CERTIFY, That I attended deceased from 8-7-23, 19 , to 8-7-23, 19 ,
that I last saw h living alive on 8-7-23, 19 ,
and that death occurred, on the date stated above, at 8 45 m.

The CAUSE OF DEATH* was as follows:

Sinusitis

(duration) yrs. mos 3 5 ds.

CONTRIBUTORY (Secondary) Abd Abscess

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & pathological

(Signed) Jno A Wimpfheimer, M. D.

, 19 (Address) Md Gen Hospl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Buckhannon W Va	Aug 8 1923
20 UNDERTAKER Jos Joerdens Son	ADDRESS 217 S. Bdwy

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT IS RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No acute history

Gibson

Spec.—1-10-21—M&T—1500 Bks.

D78150

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78150

CERTIFICATE OF DEATH.

X38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 Summit St. ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ginger D. Gibson

(a) RESIDENCE NO. 1813 Summit St. ST., WARD Guilford Heights

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah J Roderick

6 DATE OF BIRTH (month, day, and year) Nov 2. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md U.S.

PARENTS

10 NAME OF FATHER Ginger Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Hardesty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Geo. Gibson

(Address) Guilford Hts

15 Filed AUG 8 - 1923, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1923

17

I HEREBY CERTIFY, That I attended deceased from July 25, 1923, to Aug 6, 1923, that I last saw him alive on Aug 5, 1923, and that death occurred, on the date stated above, at 2 00 a.m.

The CAUSE OF DEATH* was as follows:

Aneurysm of Aorta (Transverse)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Worley Horsley, M. D.

Aug 7, 1923 (Address) 719 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Aug 8	1923
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Fayette

AUG 8 - 1923 Burial Permit Clerk.

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Lucie

Spec—12-23-21—E.B.R.S.—400 Blks.

D78151

HEALTH DEPARTMENT—CITY OF BALTIMORE

45 D78151

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1915 Kennedy ave St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Alice Medora Burnekes

(a) Residence No. 1915 Kennedy ave St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Widowed.

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John W. Late

6-DATE OF BIRTH (month, day and year) Feb. 1. 1849

7-AGE, 74 yrs. mos. ds. If LESS than 1 day, hrs. nr. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md. Frederick County.

PARENTS.

10-NAME OF FATHER. Dennis Grumbein

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Frederick Md.

12-MAIDEN NAME OF MOTHER. Alice McGrumbein

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Frederick Md.

14- (Informant) Wm. Hazel Burnekes

(Address) 1915 Kennedy Ave

15- Filed AUG 8 - 1923 ROBERT N. KRAUSE Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 6/23

17- I HEREBY CERTIFY, That I attended deceased from June 1 1923 to Aug 6 1923

that I last saw h[illegible] alive on Aug 5 1923

and that death occurred, on the date stated above, at 9a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Intestines

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) 2

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? 2

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) L. C. Mehl M. D.

Aug 6, 1923 (Address) 1903 W. Mt. Hy.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Druid Ridge Cemetery	Aug 8th 1923
20-UNDERTAKER.	ADDRESS
Geo. J. Ruth	1733 Edmondson Ave.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78152

CERTIFICATE OF DEATH.

131 D78152

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 21 WARD)

2-FULL NAME Mrs. Catharine Brooks.

(a) RESIDENCE NO. 300 Belair Rd. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene Brooks

6 DATE OF BIRTH (month, day, and year) 4/4/1875

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
48	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wm. Wagner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret K.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Eugene Brooks. (Address) 300 Belair Rd.

15 Filed AUG 8 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1923, to Aug. 7, 1923, that I last saw her alive on Aug. 7, 1923, and that death occurred, on the date stated above, at 8 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency 3 de.

(duration) yrs. mos.

CONTRIBUTORY (Secondary) Cystic Kidney

(duration) 2 yrs. mos. de.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 8-1-23

Was there an autopsy? Not

What test confirmed diagnosis? Operation

(Signed) J. C. Fezerlick, M. D.

19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 9 1923
20 UNDERTAKER	ADDRESS
Geo. J. Ruth	1735 Hayford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78153 HEALTH DEPARTMENT—CITY OF BALTIMORE D78153

CERTIFICATE OF DEATH.

175

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2109 Mc Culloh ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jno. H. Thomas

(a) RESIDENCE No. 2109 Mc Culloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Thomas

6 DATE OF BIRTH (month, day, and year) March 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab.

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jno H. Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Jno. H. Thomas (Address) 2109 Mc Culloh St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/5- 1923

17 I HEREBY CERTIFY, That I attended deceased from 8/5- , 1923 , to 8/5- , 1923 ,

that I last saw h[illegible] alive on 8/5- , 1923 ,

and that death occurred, on the date stated above, at 7.40 P m.

The CAUSE OF DEATH* was as follows:

Ac. Gastritis with Pleumonia Lobaris & Obstipation.

Pleumonia Lobaris (duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) (Eating Crab Salad)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Brightbill M. D.

8/6, 1923 (Address) 2134 N. Gay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn DATE OF BURIAL Aug 8 1923

20 UNDERTAKER Jno. H. Fradin ADDRESS 142 N. Eutaw St.

ROBERT A. KRAUS

Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78154

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

144 D78154

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 14th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Harry C. Held.

(a) RESIDENCE NO. Towson, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura Lewis Held.

6 DATE OF BIRTH (month, day, and year) June 28, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Lewis M. Held.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Frederica Bryer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Ida Held

(Address) Towson.

15 Filed AUG 8 1923 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1923

17

I HEREBY CERTIFY, That I attended deceased from July 24, 1923, to Aug 7, 1923, that I last saw him alive on Aug 7, 1923, and that death occurred, on the date stated above, at 2.35 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma, intra abdominal. (of the Stomach)

(duration) yrs. 6+ mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H B Price M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill Cem	Aug 8th, 23
20 UNDERTAKER	ADDRESS
John Burns Sons	Towson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78155

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 D78155

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1118 William ST. 24 WARD)

2-FULL NAME Frances D Mills

(a) RESIDENCE No. 1118 William ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) July 8 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	[redacted]	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) md

PARENTS

10 NAME OF FATHER Edward Mills

11 BIRTHPLACE OF FATHER (city or town) Cambridge
(State or country) Md

12 MAIDEN NAME OF MOTHER Agnes D McCauley

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mr Edward Mills
(Address) 1118 William st

15 AUG 8 1923 ROBERT R. KRAUTER
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1923, to Aug 7/23, 19..., that I last saw her alive on Aug 7/23, 19..., and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Convulsions ..... (duration) ..... yrs. ..... mos. 1/2 ds.

CONTRIBUTORY (Secondary) Inflammatory Rheumatism (duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? ..... yes

Did an operation precede death? ..... yes Date of —

Was there an autopsy? ..... no

What test confirmed diagnosis? .....

(Signed) Henry B Kolb M. D.

(Address) 1103 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A&C — DATE OF BURIAL Aug 8 1923

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78156 + 12 f D78156

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital — REGISTERED NO.

CITY OF BALTIMORE: (No. Cor. Lombard & Greene ST. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Duncan.

(a) RESIDENCE NO. Cowart Virginia ST., ... WARD Cowart, Virginia
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 4 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, (Married), Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nettie Long Duncan

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Garret Duncan

11 BIRTHPLACE OF FATHER, (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Hospital Records.
(Address)

15 Filed AUG 8 1923, 19... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from August 3, 1923. to August 7. 1923.

that I last saw him alive on August 7, 1923.

and that death occurred, on the date stated above, at 12:10 P m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis (B. Coli).

(duration) ... yrs. ... mos. 9. ds.

CONTRIBUTORY (Secondary): Cholemia.

(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? Cowart Virginia

Did an operation precede death? yes Date of August 3, 1923

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) ..... M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cowart Va

DATE OF BURIAL: 8/A 23

20 UNDERTAKER: H A Wolfe

ADDRESS: 1531 W Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78157

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

6 2!

D78157

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 229 N. Bond ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Smith

(a) RESIDENCE. No. 229 N. Bond ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fe

4 COLOR OR RACE: B

5 Single, Married, Widowed, or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1894

7 AGE: Years 29 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Home

9 BIRTHPLACE (city or town) (State or country): Rockhall S. C.

PARENTS

10 NAME OF FATHER: Albert Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): S. C.

12 MAIDEN NAME OF MOTHER: Sarah Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. C.

14 Informant: Winston Smith

(Address): 229 N Bond

15 Filed , 19

ROBERT A. KRAUL M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8 — 5 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1923, to Aug 5, 1923, that I last saw h[illegible] alive on Aug 5, 1923, and that death occurred, on the date stated above, at 9.55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Th.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Bornstein, M. D.

8/16, 1923 (Address) 722 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Aug 9 1923

20 UNDERTAKER — ADDRESS: B. Lewis 1405 McCulloh

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78158

CERTIFICATE OF DEATH.

57

D78158

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 N. Carrollton ave ST. 16 WARD)

2-FULL NAME Emma M. Hoyt

(a) RESIDENCE NO. 611 N. Carrollton ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of, Capt Alfred Hoyt

6 DATE OF BIRTH (month, day, and year) March 19 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Boston Mass
(State or country)

PARENTS

10 NAME OF FATHER William W. Sprague

11 BIRTHPLACE OF FATHER (city or town) Boston Mass
(State or country)

12 MAIDEN NAME OF MOTHER Lydia Davis

13 BIRTHPLACE OF MOTHER (city or town) ...
(State or country) Mass

14 Informant Mrs Harriett Bellows
(Address) 611 N. Carrollton ave

15 AUG 8 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Mch - 18, 1923, to Aug 7 - , 1923,
that I last saw her alive on Aug 6, 1923,
and that death occurred, on the date stated above, at 9:50 a. m.
The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) — yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus + Mitral Regurg. taken to my knowledge by me
(duration) several yrs. — mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sugar test +

(Signed) M Bowmanstood, M. D.

8/7, 1923 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL Aug 8 1923

20 UNDERTAKER Chas. G. Black — ADDRESS 742 W North ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78159

CERTIFICATE OF DEATH.

3 X 32

D78159

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Hernandez

(a) RESIDENCE. NO. 1836 E. Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 3 mos. 0 ds. How long in U. S., if of foreign birth? 3 yrs. 2 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Spanish	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 20, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Havana, Cuba
(State or country)

PARENTS

10 NAME OF FATHER Corodo Hernandez

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Porto Rico.

12 MAIDEN NAME OF MOTHER Corona Placo

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Porto Rico.

14 Informant Corodo Hernandez.
(Address) 1836 E Lombard st

15 Filed AUG 8 - 1923, 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1923, to Aug 8, 1923, that I last saw h er alive on Aug 8, 1923, and that death occurred, on the date stated above, at 4 [illegible] A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of menenges

(duration) 0 yrs. 2 mos. 18 ds.

CONTRIBUTORY
(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Regis G. Wilson M. D

, 19 (Address) Hebrew Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmell	Aug 8 1923
20 UNDERTAKER Joseph ahrens	ADDRESS 221 Bway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

165-293 D78160

CERTIFICATE OF DEATH.

185 D78160

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Cooper

(a) RESIDENCE NO. 1011 E. Pratt St. City ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Charles E. Cooper (son), 149 N. Milton Ave.

6 DATE OF BIRTH (month, day, and year) — 1837.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
86	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER Clark.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eng.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Records. (Address) JOHNS HOPKINS HOSPITAL

15 AUG 8 - 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1923, to Aug 6, 1923, that I last saw her alive on Aug 6, 1923, and that death occurred, on the date stated above, at 3:20 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Fracture neck of Femur,

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? J. H. Hosp.

Did an operation precede death? No Date of

Was there an autopsy? No Refused.

What test confirmed diagnosis? Phys. Examination

(Signed) Julian D. Hall, M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park cemetery	8-9-23 19
20 UNDERTAKER	ADDRESS
H.E. Hughes	424 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accidental Fall down steps at home

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78161

CERTIFICATE OF DEATH

D78161

REGISTERED NO. 74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ~~35 South Eastern Ave~~ 2 ~~South Potomac~~ St. ~~WARD~~)

2-FULL NAME Isaac Henry Knight

(a) RESIDENCE NO. 35 South East Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widowed

5a If ~~married~~, widowed, ~~divorced~~ HUSBAND of ~~WIFE~~ Mary Knight

6 DATE OF BIRTH (month, day, and year) Jan. 15. 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	74	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ellicott City (State or country) Md

PARENTS

10 NAME OF FATHER John Knight

11 BIRTHPLACE OF FATHER (city or town) Ellicott City (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Lewis

13 BIRTHPLACE OF MOTHER (city or town) Ellicott City (State or country) Md.

14 Informant Mr. Knight (Address) 3 S. Potomac St.

15 Filed AUG 8 1923, 19 ROBERT K. KRAUER, Registrar. Burial Permit Issued.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1st 1923 to Aug 6 1923, that I last saw h~~im~~ alive on Aug 6 1923, and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

3

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Tod, M. D.

, 19 (Address) 4704 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	8-9-23 19
20 UNDERTAKER	ADDRESS
H.E. Hughes	424 N. Broadway

(N. B. WHERE PRACTICABLE, WITH CHILDREN OF FOREIGN PARENTAGE, THIS INFORMATION SHOULD BE OBTAINED FROM THE PARENTS. EVERY ITEM OF INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.)

Spec.—8-24-14—M. & T.—2000 Bks.

D78162

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 D78162

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 Division ST.: 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie Oliver

(Residence in Baltimore: No. 1114 Division St.: 49 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, 8 (Month) 2 (Day), 1874 (Year)

7-AGE, 47 yrs. 3 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): 470

9-BIRTHPLACE, (State or Country), Baltimore, Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Oliver

(Address) 1114 Division St

15- AUG 8 - 1923 Filed ....., 192.. ROBERT F. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 5 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 13 1923, to Aug 5th 1923, that I saw her alive on Aug 4th 1923, and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ....yrs. ....mos. 27 ds.

CONTRIBUTORY (Secondary) Dropsy

(Duration) ....yrs. ....mos. 21 ds.

(Signed) D Baughman M. D.

Aug 8th 1923. (Address) 1354 N. Bethel St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cem

DATE OF BURIAL, 8 (Month) 8 (Day), 1923 (Year)

20-UNDERTAKER Sam'l Kenealy

ADDRESS 1358

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D78163

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 90 D78163

1-PLACE OF DEATH
City of BALTIMORE: (No. Died enroute to Hebrew Hospital from Union R.R.Station. St., 9 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Louis Fine

(Residence in Baltimore: No. Miama Florida St.; yrs.....mos...1...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	unknown

6-DATE OF BIRTH. unknown (Month) 1 (Day) (Year)

7-AGE. Probably 50 Yrs. mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Merchant?
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Unknown

PARENTS.

10-NAME OF FATHER.	"
11-BIRTHPLACE OF FATHER, (State or Country).	"
12-MAIDEN NAME OF MOTHER.	"
13-BIRTHPLACE OF MOTHER, (State or Country).	"

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Obtained from effects on person
(Address).....

15- Date AUG 8 - 1923 192 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 7/23 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Myocardial Dilatation

(Duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) unknown

(Duration) ....yrs....mos....ds.

(Signed) J S H Fallon M. D.
(Coroner.)

8/8/23 192 (Address) 508 E. North Ave

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Miama Florida DATE OF BURIAL. 8/11 192 3

20-UNDERTAKER. Jack Lewis ADDRESS 1439 E Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78164

CERTIFICATE OF DEATH.

D78164

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 3 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Rose Cornell

(a) RESIDENCE No. 1429 Gough St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced~~, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
76	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Mr Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Mrs Fanny Cornelsen (Address) Carolina & Lexington sts

15 Filed , 19 ROBERT A. KRAUTER Registrar

A068 - 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 - 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 7 , 1923 , to Aug 7 - , 1923 ,

that I last saw h alive on Aug 7 - , 1923 ,

and that death occurred, on the date stated above, at 6.20 P. M.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) none.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Alexander Novey M. D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Lodge DATE OF BURIAL 8/9 1923

20 UNDERTAKER Jack Levis ADDRESS 1439 Gough St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough: Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Chr. Endocarditis
Result of Rheumatic
Fever during Child-
hood.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78165 61-001 D78165

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maternity Hospital St. 13 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Kotus (1760) "Twin"

(Residence in Baltimore: No. 3709 Mondawmin Ave St.; ....yrs., ...mos. ....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	

6-DATE OF BIRTH, Aug 7, 1923
(Month) (Day) (Year)

7-AGE, ...yrs....mos....da. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Albert S Kotus

11-BIRTHPLACE OF FATHER (State or Country), New York City

12-MAIDEN NAME OF MOTHER Mary Kratosky

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Kratosky

(Address) 3709 Mondawmin Ave

15- AUG 8 - 1923 ROBERT B. KRANTZ Registrar.

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 7, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 7 1923, to Aug 7 1923, that I saw h— alive on Aug 7 1923, and that death occurred, on the date stated above, at 7 45 m.

The CAUSE OF DEATH* was as follows:

(Premature) Immaturity

Birth

(Duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary) Malnutrition "marasmus"

(Duration) ....yrs. ....mos. ....da.

(Signed) E Brand Schmidt M. D.

Aug 7, 1923 (Address) 3709 Mondawmin Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Hebrew Friendship DATE OF BURIAL. 8/8, 1923

20-UNDERTAKER Jacob Lewis ADDRESS 1423 E Lexington

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78166 161-001 D78166

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West End. REGISTERED NO. C.....

CITY OF BALTIMORE: (No. Maternity of ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Mae Stafford

(Residence in Baltimore: No. Baby Robert no 2 St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) X

6-DATE OF BIRTH, Aug (Month) 7 (Day), 1923 (Year)

7-AGE, ...yrs.....mos.....ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Albert S Robey

11-BIRTHPLACE OF FATHER (State or Country). New York City

12-MAIDEN NAME OF MOTHER Mary K Oakley

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary K Oakley

(Address) 230 Monument Ave

15-

Filed AUG 8 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 7 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 7 1923, to Aug 7 1923, that I saw h... alive on Aug 7 1923, and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Fractured Skull

..... (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) Accidental injuries

..... (Duration) .....yrs.....mos.....ds.

(Signed) Edward L Tuttle M. D.

Aug 7, 1923 (Address) 1707 Eutaw Pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death .....yrs.....mos.....ds. In the State .....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Hebrew Friendship	Aug 9, 1923
20-UNDERTAKER	ADDRESS
Jack Levin	1439 E Balto St

P. S.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1923 65 1864

D78167

CERTIFICATE OF DEATH.

74-001

D78167 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2108 McCulloh ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E Wilson

(a) RESIDENCE No. 2108 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H Wilson

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER William Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mariah Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mary P Mackey

(Address) 2108 McCulloh St

15 Filed AUG 8 1923 19 Burial Permit Issued by ROBERT F. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1923, to Aug 6, 1923, that I last saw her alive on Aug 6, 1923, and that death occurred, on the date stated above, at 5.1 m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

Apoplexy 2 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. H. Magruder, M. D.

, 19 (Address) 14 East Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel — DATE OF BURIAL Aug 9 1923

20 UNDERTAKER James E Wright — ADDRESS 1361 Mary

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78168

CERTIFICATE OF DEATH.

16 D78168

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Hughes

(a) RESIDENCE NO. 808 N. Spring ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Hane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Cora Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant W.W. Gray

(Address) Johns Hopkins Hospital.

15 Filed AUG 3-1923 ROBERT F. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1923, to June 4, 1923.

that I last saw him alive on June 4, 1923,

and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W.W. Gray, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: Aug 4 1923

20 UNDERTAKER: Consulting Interne Hosp.

ADDRESS

THIS STATEMENT IS PRIMARILY A MEDICAL RECORD. Every item of this information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78169

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78 D78169

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 Busk St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm E. Thompson

(a) RESIDENCE NO. 1021 Busk St., Ward

(If non-resident give city or town and State)

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. 8 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Busk

6 DATE OF BIRTH (month, day, and year) Nov 9-1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) City Dept Cark

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant (Address) Mrs Virginia Thompson 1021 Busk St

15 AUG 8 - 1923 ROBERT N. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6 1923

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1923 to Aug 6, 1923 that I last saw h/ alive on Aug 5, 1923 and that death occurred, on the date stated above, at 3.05 P. m.

The CAUSE OF DEATH* was as follows:

Epilepsy (Traumatic)

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) R. T. Campbell, M. D.

Aug 7, 1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Aug 9th 1923

20 UNDERTAKER John F. Conway & Son

ADDRESS Jas Wallace

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accident - Fell off Cart
1 yr. ago.

Spec.—1-10-21 M&T 1500 Bks.

D78170

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78170

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. N. W. Cor. Preston & Guilford Ave ST., 11 WARD)

2-FULL NAME Mary Whelan

(a) RESIDENCE NO. N.W.Cor. Preston & Guilford ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 10 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Oct. 1, 1856

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
66	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thomas Whelan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary Duvall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Mrs. Octavia W. Forman

(Address) Preston & Guilford Ave.

15 AUG 8 - 1923 ROBERT A. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7, 1923

17

I HEREBY CERTIFY, That I attended deceased from April, 1916, to Aug 7th, 1923, that I last saw her alive on August 6th, 1923, and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Hypertension

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Progress

(Signed) J. A. Blatland, M. D.

Aug 7th, 1923 (Address) 40 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	8/9/23 19
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son,	805 Calvert St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78171

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mercy Hospital — Registered No. 701-001 D78171

City of BALTIMORE: (No. Calvert & Saratoga Sts. W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Brother Gaston

(a) Residence No. Ammondale St., Maryland Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? 3 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 12, 1870

7-AGE, 53 yrs. 0 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Religious
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Caspar Schaefer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Anna Zeigler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Hosp. Records

(Address)

15- Filed AUG 1923 192 Robert F. Merriken Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 7-23

17- I HEREBY CERTIFY, That I attended deceased from July 24, 1923 to Aug. 7, 1923

that I last saw h[illegible]ive on Aug 7 1923

and that death occurred, on the date stated above, at 150 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? Ammondale - Md

Did an operation precede death? N.G. Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. Allen McCoy M. D

, 19 (Address) Mercy Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Ammondale Md. DATE OF BURIAL, 8/8/23

20-UNDERTAKER, E & R Slade ADDRESS 115 E Wash St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78172 D78172

CERTIFICATE OF DEATH

1-PLACE OF DEATH University Hosp.

CITY OF BALTIMORE: (No. Fayette & Greene ST., S 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Lyle

(a) RESIDENCE No. 820 Lemmon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ??

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Elias Shilling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Emma Sowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hosp. Records (Address)

15 Filed , 19 Robert F. Hartsock, Registrar

AUG 9 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-8 1923

17 I HEREBY CERTIFY, That I attended deceased from 7-1, 1923, to 8-8, 1923, that I last saw her alive on 8-8, 1923, and that death occurred, on the date stated above, at 11:55 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia.

Toxic myocarditis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Sigmoid metastatic Epithelial (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7-26-23

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Damascus, Md.

DATE OF BURIAL: 8-8 1923

20 UNDERTAKER: E & B Hasle

ADDRESS: 115 E Mosher St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Baskin)

Spec.—1-10-21—M&T—1500 Bks.

16 5387. D78173

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78173

CERTIFICATE OF DEATH.

X 71-00

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Baskin

(a) RESIDENCE NO. 3220 17th St Washington, D.C. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Unknown · How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a ~~If married, widowed, or divorced~~ HUSBAND of (or) WIFE of ~~Horace (mother)~~.

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 7. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) D. C.

PARENTS

10 NAME OF FATHER Morris Baskin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia ?

12 MAIDEN NAME OF MOTHER Bella Low

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boston Mass

14 Informant Records Johns Hopkins Hospital

(Address)

15 Filed AUG 8 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 7, 1923

17

I HEREBY CERTIFY, That I attended deceased from July 28, 1923, to August 7, 1923, that I last saw him alive on August 7, 1923, and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis - Hydrocephalus

probably pneumococcus -

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) [redacted]

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Bacteriological culture

(Signed) Warfield M Jones, M. D.

8/12, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D.C. DATE OF BURIAL: Aug. 8 1923

20 UNDERTAKER: Jacob Heuisler ADDRESS: 1439 Bank

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78174

CERTIFICATE OF DEATH.

9 1002 D78174

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt. Hope Retreat ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Gessler

(a) RESIDENCE. NO. Mt. Hope Retreat ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Gessler

6 DATE OF BIRTH (month, day, and year) June 1. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	67	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber.

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Gessler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Brous.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mt. Hope Retreat.
(Address)

15 Filed ..., 19 Robert F. Hartlack Registrar

UGB-1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8 1923.

17 I HEREBY CERTIFY, That I attended deceased from July 31 1923, to August 8, 1923.,
that I last saw him alive on August 8, 1923.,
and that death occurred, on the date stated above, at 4.55 A. m.
The CAUSE OF DEATH* was as follows:

Enteritis

Senile Psychosis (duration) yrs. mos. 7 ds.
and
CONTRIBUTORY (Secondary) Arteriosclerosis.
unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical

(Signed) Milton P. Hill, M. D.

19 (Address) Wyliesar - Reisterstown Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug 11 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E Ward St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78175

CERTIFICATE OF DEATH

164 D78175

1-PLACE OF DEATH 104 N. Arlington Ave. REGISTERED NO.

CITY OF BALTIMORE: (No. 104 ST., 16 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth A. Smith

(a) RESIDENCE NO. 104 N. Arlington Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or Divorced, (~~write the word~~): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 23, 1842

7 AGE: Years 81; Months; Days; If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: John P. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Hannah Seay

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Sarah Smith (Address): 104 N Arlington Ave.

15 Filed ....., 19.... Registrar

AUG 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1923, to Aug 7, 1923, that I last saw her alive on Aug 6, 1923, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Senility- old age

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas H. Buhrt, M. D.

Aug 8, 1923 (Address) 1100 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Aug 10 1923

20 UNDERTAKER: Wm Cook — ADDRESS: 704 E North Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D78176 HEALTH DEPARTMENT—CITY OF BALTIMORE D78176

CERTIFICATE OF DEATH.

161-60

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 Fort Ave ST.; 24 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Infant of John & Bessie Lang.

(Residence in Baltimore: No. 1520 Fort Ave St.; — yrs., mos. ½ ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, 8 (Month) 8 (Day) 1923 (Year)

7-AGE, ——— yrs. ——— mos. ——— ds.

If LESS than 1 day, ——— hrs. or 15 min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Baltimore.

PARENTS.

10-NAME OF FATHER, John Lang

11-BIRTHPLACE OF FATHER (State or Country), Baltimore

12-MAIDEN NAME OF MOTHER Bessie Buttle

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Groth, M.D.

(Address) 2202 W North Ave.

15- Albert F. Harrison,
Filed AUG 8 1923, 191.... Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, 8 (Month) 8 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 8-8-1923, to 8-8-1923, that I saw her alive on 8-8-1923, and that death occurred, on the date stated above, at 8.30 a m.

The CAUSE OF DEATH* was as follows:

Premature birth

(6 months in utero)

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY ———
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. Groth M. D.

8-8-, 1923 (Address) 2202 W North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, First Evangelical Cem

DATE OF BURIAL, 8, 1923

20-UNDERTAKER J. F. McCully

ADDRESS 130 E. Fort

19. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-1 10-21-M&T-1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78177 D78177

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 801-E-33rd ST. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carroll T. Fretwell

(a) RESIDENCE NO. 801-E.-33rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875-3-1

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	48	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar Dealer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norfolk Va

PARENTS

10 NAME OF FATHER Fretwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Addie C. Simms

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Addie A. Swift

(Address) Atlantic City N.J.

15 Filed ....., 19..... Registrar

AUG 8 - 1923

Robert P. Harrison

Chief Registration Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1923

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1923, to Aug 7, 1923.

that I last saw him alive on Aug 7, 1923.

and that death occurred, on the date stated above, at 11.50 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Myocarditis)

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) (Pneumonia) Bronchus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? Yes Date of

Was there an autopsy? (Clinical)

What test confirmed diagnosis?

(Signed) N. Bowerman, M. D.

, 1923 (Address) 305 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pleasantville - N.J. DATE OF BURIAL: 8-9 1923

20 UNDERTAKER: Henry J. Eutsler Sons Co ADDRESS: Hillcrest Orchard

WORK PENCIL, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D78178

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

D78178

1-PLACE OF DEATH

REGISTERED No. C

CITY OF BALTIMORE (No. 4214 Groveland Ave ST. 28 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ann Virginia McCaffrey

(Residence in Baltimore: No. 4214 Groveland Ave, Arlington St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word)
female	white	widow

6-DATE OF BIRTH: July (Month) 28 (Day), 1846 (Year)

7-AGE: 77 yrs. — mos. 11 ds. | If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE (State or country): Frederick Co Md

PARENTS

10-NAME OF FATHER: Philip Hardy.

11-BIRTHPLACE OF FATHER (State or country): Frederick Co Md

12-MAIDEN NAME OF MOTHER: Rebecca Buckey.

13-BIRTHPLACE OF MOTHER (State or country): Carroll Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Mamie McCaffrey

(Address) 4214 Groveland Ave

15. AUG 9 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: August (Month) 8 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12, 1923 to Aug 8 1923, that I saw h[illegible] alive on Aug 8, 1923, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. 6 mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Marshall B Hirst M. D.

Aug 8, 1923 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Frederick Md	Aug 11 1923
20-UNDERTAKER C C Carty	ADDRESS Frederick Md

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

078179 ✓ 164 078179

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1404 W. Lexington ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Jefferson

(a) RESIDENCE NO. 1404 W. Lexington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30 1826

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	97	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Annapolis Md

PARENTS

10 NAME OF FATHER: Richard Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Annapolis Md

12 MAIDEN NAME OF MOTHER: Mary Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Annapolis Md

14 Informant: Ella Thorpe

(Address): 1404 W. Lexington St

15 Filed: AUG 9 - 1923

ROBERT F. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923 to Aug 7, 1923, that I last saw her alive on Aug 7, 1923 and that death occurred, on the date stated above, at 9:00 A. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Infirmities of Age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) James Z. Thorpe, M. D.

8/8, 1923 (Address) 3462 E. Lan —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Aug 9 1923

20 UNDERTAKER: George J. Smith — ADDRESS: 1332 Hollins st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78180

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D78180

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 525. S. Milton Ave. ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Izdebski

(a) RESIDENCE NO. 525 S. Milton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July. 30-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Infant

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER John Izdepski

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Julia Sawzyk

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant John. Izdepski
(Address) 525 S. Milton.

15 Filed AUG 8 1923 19 ROBERT R. KRACTEN, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/7 19 23

17

I HEREBY CERTIFY, That I attended deceased from August 6 , 19 .. to August 7 , 19 23 ,

that I last saw h alive on August 7 , 19 ..,

and that death occurred, on the date stated above, at 4:30 p m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

8/8, 19 (Address) 1628 E

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanis Cem	Aug 9 1923
UNDERTAKER	ADDRESS
William Gaerfoski	1628 Eden St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma" "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Primary

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78181 — REGISTERED No. 74-001 D78181

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 654 Cider alley ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Wilson

(a) RESIDENCE No. 654 Cider alley ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Marr'd

5a If married, widowed, or divorced HUSBAND of (or) WIFE of L

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Julia Wilson
(Address) 654 N. Carrollton Ave

15 Filed AUG 9 - 1923 19.. ROBERT R. KRAUTER, Registrar
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-5- 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy 2 days

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. K. Lynch, M. D.
(Coroner.)

8-7- 1923 (Address) 311 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	8-9-1923
20 UNDERTAKER David Easton	ADDRESS 916 Pa Ave

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D78182

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78182

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 3715 Fernwood Ave St. 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry L. Powell

(a) Residence No. 3715 Fernwood ave St. Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed or Divorced (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: -

6-DATE OF BIRTH (month, day and year): Aug. 18-1922

7-AGE. - yrs. 11 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto., Md

PARENTS.

10-NAME OF FATHER: Ellsworth Powell

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto., Md.

12-MAIDEN NAME OF MOTHER: Catharine Mallon

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto., Md.

14- (Informant): Catharine Powell

(Address): 3715 Fernwood Ave

15- Filed AUG 9 - 1923 ROBERT A. KRAUTER Registrar.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug. 8-1923

17- I HEREBY CERTIFY, That I attended deceased from 8/7 1923 (to) 8/8 1923, that I last saw h.. alive on 8/8 1923 and that death occurred, on the date stated above, at 2 P.M. The CAUSE OF DEATH* was as follows:

Lobar pneumonia

2 (Duration) ....yrs. ....mos. ....ds

CONTRIBUTORY (Secondary)

.....(Duration) ....yrs. ....mos. ....ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D

(Address) 643 S. Third St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	Aug 9 1923
20-UNDERTAKER.	**ADDRESS**
Zinkler + Zinkler	1739 E Eager St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21- E.B.R.S.—400 Bks.

D78183 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D78183

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., 26 Ward) 74

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph W. Steiner

(a) Residence No. Bay View Hospital. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1865

7-AGE. 65 yrs. ... mos. ... ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS:
10-NAME OF FATHER, Daniel Steiner
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland
12-MAIDEN NAME OF MOTHER, ?
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Municipal Hospital Records
(Address)

15- Filed AUG 9 - 1923 ROBERT R. KRAUTER Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) August 8, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 4 1923 to August 8 1923
that I last saw him alive on August 7 1923
and that death occurred, on the date stated above, at 4:00 A.M.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Right Hemiplegia (thrombotic)

(Duration) ... yrs. 1½ mos. ... ds

CONTRIBUTORY (Secondary) (Duration) ... yrs. ... mos. 5 ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude A Grace M. D
8-8-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent	Aug. 11, 1923
20-UNDERTAKER,	ADDRESS
Roth & Turner Inc	19 Broadway

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78184

HEALTH DEPARTMENT—CITY OF BALTIMORE

603

D78184

CERTIFICATE OF DEATH.

18 X 18 D78184

1-PLACE OF DEATH

City of BALTIMORE: (No. Dr Sq Hospital St., ... Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs. Keziah

(Residence in Baltimore: No. 1216 W. Lexington St. St.; yrs. 6 mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, ~~Married, Widowed, or Divorced~~ (Write the word.)

6-DATE OF BIRTH. March 4 (Month) (Day) 1914 (Year)

7-AGE, 9 yrs. 6 mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Ga

PARENTS.

10-NAME OF FATHER. Emmett Keziah

11-BIRTHPLACE OF FATHER, (State or Country) Ga

12-MAIDEN NAME OF MOTHER. Flora Aldridge

13-BIRTHPLACE OF MOTHER, (State or Country). Ga

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emmett Keziah

(Address) 1216 W Lexington St

15-

Filed ....., 192.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 6 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Multiple Fractures
Auto Accident

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Elmer Bladel M. D.
(Coroner)

Aug 7 23 (Address) 436 N Bond

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence Georgia

PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

St Marys Hampden Aug 10 23

20-UNDERTAKER ADDRESS

Chenoweth Son Chestnut Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D78185

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78185

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3146 Cedar Ave. WARD) 12

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H Wisner

(a) RESIDENCE No. Mt Carmel Balto Co

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel Wisner

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Rachel J Wisner

(Address) 3146 Cedar Ave

15 Filed AUG 9 1923, 19 ROBERT A. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923 to Aug 7, 1923

that I last saw him alive on Aug 6, 1923

and that death occurred, on the date stated above, at 130 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

& myocarditis

(duration) yrs. 2 mos. 7 ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. F. Cookley M. D.

Aug 7, 1923 (Address) 3701 Reed Alley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Balto Co

DATE OF BURIAL Aug 10 1923

UNDERTAKER CHERNOWETH & SON,

ADDRESS 3617 CHESTNUT AVE.

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78186

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

87 D78186

REGISTERED NO. 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hosp. for Women 7 Md. John ST. 12 + Lafayette Ave. WARD)

2-FULL NAME Pearl Towne

(a) RESIDENCE NO. 2437 N. Charles ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Towne

6 DATE OF BIRTH (month, day, and year) July 5, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk, Va. (State or country)

PARENTS

10 NAME OF FATHER James E Etheredge

11 BIRTHPLACE OF FATHER (city or town) Va (State or country)

12 MAIDEN NAME OF MOTHER Caroline Hamby

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Peter E. Towne (Address) 2437 N Charles St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 5 . 1923 . to Aug. 7 . 1923 . that I last saw her alive on Aug 7 . 1923 . and that death occurred, on the date stated above, at 6 35 A m.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis

(duration) (?) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) G. F. Goff M. D.

. 19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodland Cem	Aug 9 1923
20 UNDERTAKER	ADDRESS
John A Mitchell	120 W Lafayette

R.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78187 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 188-002 D78187

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. Mercy Hospital 21 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James L Patterson

(Residence in Baltimore: No. William Road Mt Washington St.; yrs. 60 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-~~Single~~, Married, Widowed, or Divorced. (Write the word.) Married

6-DATE OF BIRTH. March (Month) 14 (Day) 1863

7-AGE. 59 yrs. 4 mos. 23 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Jeweler
(b) General nature of industry, business, or establishment in which employed (or employer) Salesman

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. James R Patterson

11-BIRTHPLACE OF FATHER, (State or Country). Baltimore Md

12-MAIDEN NAME OF MOTHER. Sarah Perry

13-BIRTHPLACE OF MOTHER, (State or Country). Norwich Conn

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo W Little

(Address) 2700 EDMONDSON AVE.

15- ~~Registrar~~

Filed AUG 9 - 1923 19.. ROBERT R. KRAUSE Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug (Month) 7 (Day) 23 (Year) 192..

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fall
Fracture of Skull
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Shock
(Duration) yrs. mos. ds.

(Signed) F. C. Blades M. D.
(Coroner)
(Address) 43 W Ky

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL ~~OR REMOVAL~~. DATE OF BURIAL.
Mt Olivet AUG 10 1923

20-UNDERTAKER. Geo W Little ADDRESS 2700 EDMONDSON AVE.

78187

DR. GEO. CLINTON BLADES

143 N. BROADWAY

OFFICE HOURS
9 10 A. M.
7 8 P. M.

C. & P. PHONE
WOLFE 4020

D 78187

REG NO. 309

DATE

Rx NAME ADDRESS

Please - hand copy of
Mrs Jane L Bleeme
60 yrs to 59 -
Date 1863 5
Love
G. C Blades

Spec.—1-10-21—M&T—1500 Blks.

D78188

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78188

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hosp't ST., 14 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Hall.

(a) RESIDENCE NO. 1731 Cole St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: FEMALE

4 COLOR OR RACE: WHITE

5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of: John Hall

6 DATE OF BIRTH (month, day, and year): June 9 1885

7 AGE: Years 38; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Carroll Co Md

PARENTS

10 NAME OF FATHER: Isaac E Haines

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co Md

12 MAIDEN NAME OF MOTHER: Sarah Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co Md

14 Informant: John Hall (Address) 1731 Cole ST

15 Filed AUG 9 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-8-1923

17

I HEREBY CERTIFY, That I attended deceased from 8-5-23, 19 , to 8-8-23, 19 ,

that I last saw h alive on 8-8-23, 19 ,

and that death occurred, on the date stated above, at 12 45 am.

The CAUSE OF DEATH* was as follows:

Ch. Myocarditis.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (Acute Cardiac Gil. (Recognition) (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clynical Signs

(Signed) John A Stumpfunic, M. D.

, 19 (Address) Md Gen Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOWARD Poplar Springs Co Md

DATE OF BURIAL: 8-11 1923

20 UNDERTAKER: ROBT. BROOKS SON

ADDRESS: 608 CALHOUN HOLLINS ST

WORK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78188

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78189

CERTIFICATE OF DEATH.

160 D78189

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Ga. Balto. Gen. Hosp. ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Robert E. Lacer

(a) RESIDENCE NO. 1109 Hall alley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/4/'23

7 AGE — Years: — Months: 1 Days: 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) md.

PARENTS

10 NAME OF FATHER George Lacer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Myrtle Hagner

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant Geo. Lacer. (Address) 1109 Hall Alley

15 Filed AUG 9 1923 ROBERT R. KRAETER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-9-1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 6, 1923. to Aug 9, 1923.

that I last saw him alive on Aug 9, 1923.

and that death occurred, on the date stated above, at 2:50 a.m.

The CAUSE OF DEATH* was as follows:

Marasmus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) marasmus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. Wardlaw, M. D.

8/9, 1923 (Address) South Boston Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross C & B — DATE OF BURIAL: 8-10, 1923

20 UNDERTAKER: E & B Harla — ADDRESS: 115 E Ma[illegible]

N. B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Malnutrition – Inability to assimilate food.

Spec.—1-10-21—M&T—1500 Bks.

165-575 D78190

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 123 D78190

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Cox

(a) RESIDENCE No. Fairmont, W. Va. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John D. Cox

6 DATE OF BIRTH (month, day, and year) June 26-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W. 37

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER John May

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Selinda Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant (Address) Records

15 Filed AUG 9 - 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9th 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 1st, 19 23 to Aug 9th, 19 23.

that I last saw her alive on Aug 9th, 19 23,

and that death occurred, on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Gall Stones in Gall Bladder, Common and Hepatic Duct

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Post operative Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of Aug 7 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) F. L. Reichert, M. D.

8/9, 19 23 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Fairmont W. Va — DATE OF BURIAL 8/9 1923

20 UNDERTAKER Jack Lewis — ADDRESS 1439 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78191

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78191

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital ST., 18 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle Pierson

(a) RESIDENCE NO. 126 Callender ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 8 mos. | ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 8, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Abraham Pierson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Ella Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant John J. Cowan

(Address)

AUG 9 1923 Filed 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1923, to Aug 9, 1923, that I last saw him alive on Aug 9, 1923, and that death occurred, on the date stated above, at 5 20 a m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Myron G. Fell, M. D.

19 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westview Cem	Aug 9 19
20 UNDERTAKER	ADDRESS
J J Cowan Son.	901 Hollins

IMPORTANT—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78192

CERTIFICATE OF DEATH.

X23 D78192

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Stevenson

(a) RESIDENCE NO. New Bern — ST., North Carolina WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 18 - 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Stevenson. J.H.

11 BIRTHPLACE OF FATHER (city or town) (State or country) NC.

12 MAIDEN NAME OF MOTHER Dickson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed AUG 9 1923 . 19 Registrar Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Augt 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from April 23 , 1923 to Aug 9 , 1923, that I last saw her alive on Aug 9 , 1923, and that death occurred, on the date stated above, at 10 25 A m.

The CAUSE OF DEATH* was as follows:

Epidemic encephalitis —

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? North Carolina

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Lloyd H Allen, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Bern N.C. DATE OF BURIAL 8/10 1923

20 UNDERTAKER Chas B. Evans & Son ADDRESS 1181 W. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78193

CERTIFICATE OF DEATH.

122-002 D78193

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 118 W. Montgomery ST., 12 WARD)

2-FULL NAME Mary E. Goose

(a) RESIDENCE NO. 118 W. Montgomery ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 20 yrs. — mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Goose

6 DATE OF BIRTH (month, day, and year) July, 19, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	43	—	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) Dorchester Co. (State or country) Maryland.

10 NAME OF FATHER Thomas Travers

11 BIRTHPLACE OF FATHER (city or town) Dorchester Co. (State or country) Maryland —

12 MAIDEN NAME OF MOTHER Mary E. Lane

13 BIRTHPLACE OF MOTHER (city or town) Dorchester Co. (State or country) Maryland.

14 Informant Levi Travers
(Address) 207 N. Copeland St

15 Filed ..... 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 7, 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 6, 1923, to Aug. 7, 1923, that I last saw her alive on Aug. 7, 1923, and that death occurred, on the date stated above, at 8.55 P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver —

(duration) History 9 months yrs. mos. da.

CONTRIBUTORY (Secondary) Chr. myocarditis + Chr. nephritis (duration) yrs. mos.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? none —

(Signed) Dan Strauchen M. D.

8/9. 1923 (Address) 122 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL Aug 10.

20 UNDERTAKER John H. Soadin ADDRESS 1432 Eutaw St

AUG 9 - 1923

K—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

non-alcoholic

Spec.—1-10-21—M&T—1500 Bks.

D78194

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78194

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital John + Lafayette Ave ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Mc Cay

(a) RESIDENCE NO. 3405 Greenway ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. H. Kent Mc Cay

6 DATE OF BIRTH (month, day, and year) Oct. 4, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westchester Pa.

PARENTS

10 NAME OF FATHER Charles P. Hughes

11 BIRTHPLACE OF FATHER (city or town) Westchester (State or country) Pa.

12 MAIDEN NAME OF MOTHER Caroline Hinman

13 BIRTHPLACE OF MOTHER (city or town) Philadelphia (State or country)

14 Informant Mr. H. Kent Mc Cay (Address) (3405) 5 Greenway City

15 ....., 19 Registrar

UGG-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1923

17

I HEREBY CERTIFY, That I attended deceased from July 16, 1923, to Aug 8, 1923, that I last saw her alive on Aug 8, 1923, and that death occurred, on the date stated above, at 3.10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of all abdominal organs +

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (?)

Did an operation precede death? yes Date of July 24/23

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) G. T. Goff, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westchester Pa. DATE OF BURIAL Aug 11 1923

20 UNDERTAKER Reid Trustwood & Son ADDRESS Northeast

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

4

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Stomach + Liver

D78195

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D78195

CERTIFICATE OF DEATH.

1-PLACE OF DEATH (Roland Park) Registered No. C.....

City of BALTIMORE: (No. Even Chapple Road St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Anna Hall

(Residence in Baltimore: No. Even Chapple Road St.; yrs., 30 mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced. (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH. about Unknown, 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
73 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Hall

11-BIRTHPLACE OF FATHER, (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Asked not known

13-BIRTHPLACE OF MOTHER, (State or Country). Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. William Hoes

(Address) Even Chapple Road

15-

Filed ..... 19..... Registrar.

AUG 9 - 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 8th 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular diseases of the heart

..... (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John L. Thomassen M. D. (Coroner)

Aug 9 1923 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Zion Church DATE OF BURIAL, Aug 10 23

20-UNDERTAKER. G. S. Marshall ADDRESS 3539 Roland Rd

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec- 12-23-21—E.B.R.S.—400 Bks.

D78196

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D78196

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Bright

(a) Residence No. 530 W. Hoffman St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1875

7-AGE.	If LESS than 1 day.
48 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... 074

(b) General nature of industry, business, or establishment in which employed (or employer) Steveclore

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Poet.....
(State or Country).

PARENTS.

10-NAME OF FATHER, John Bright

11-BIRTHPLACE OF FATHER (city or town)..... Md
(State or Country),

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town)..... ?
(State or Country),

14-

(Informant)... Hospital Records.

(Address).....

15-

Filed..... 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-8-1923

17- I HEREBY CERTIFY, That I attended deceased from 8/1/23 19.. to 8/8/23 19..

that I last saw h.. alive on 8/8/23 19..

and that death occurred, on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & myocardial failure

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. V. Holley M. D.

, 19 (Address) Mercy.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Peters	8-11-23
20-UNDERTAKER.	ADDRESS
Daniel Carter	Balto

AUG 9 1923

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

165007
D78197

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109-001
D78197

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Parker.

(a) RESIDENCE NO. 769 W. Mulberry St. City ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) ~~WIFE of~~ William Parker (Father),

6 DATE OF BIRTH (month, day, and year) Sept. 7, 1921.

7 AGE: Years 1 Months 11 Days 2 If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child. NW
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER William Parker.

11 BIRTHPLACE OF FATHER (city or town) (State or country): U. S.

12 MAIDEN NAME OF MOTHER Ora Washington.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant
(Address) JOHNS HOPKINS HOSPITAL, Baltimore

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1923, to Aug 9, 1923, that I last saw her alive on Aug 9, 1923, and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Retrophoryngeal abscess

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cervical Adenitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8-9-23

Was there an autopsy? No

What test confirmed diagnosis? X

(Signed) A. A. Reed, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 8-10 1923

20 UNDERTAKER Dunl Forbes

ADDRESS 4/C Bruce

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

D78198

CERTIFICATE OF DEATH.

129 D78198

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1948 Hanover St. ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth E. Rowan

(a) RESIDENCE NO. 1948 Hanover St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 11 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael W. Rowan

6 DATE OF BIRTH (month, day, and year) Sept. 6 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Bartholomew Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Theresa Engel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mildred W. Rowan

(Address) 1948 Hanover St

15 Filed ....., 19..... Registrar

069-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 9 1923

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1923 to Aug 9, 1923

that I last saw him alive on Aug 8, 1923

and that death occurred, on the date stated above, at 1-30 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) Indefinite yrs. mos ds.

CONTRIBUTORY (Secondary) Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. E. Campbell M. D.

Aug 9, 1923 (Address) 1444 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A. A. Co	8/11 1923
20 UNDERTAKER D. Few McCully	ADDRESS 130 E. Fay

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

10-4-29

10 78199

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78199

X122-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jose Cox

(a) RESIDENCE (Usual place of abode) NO. 40 Juarez St. Mexico City ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. [redacted] ds. How long in U. S., if of foreign birth? [redacted] yrs. [redacted] mos. [redacted] ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of: Mrs. Louisa Cox

6 DATE OF BIRTH (month, day, and year): 1875

7 AGE: Years 48; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Mexico

PARENTS

10 NAME OF FATHER: Rafael Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mexico

12 MAIDEN NAME OF MOTHER: Margarita Alcaraz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mexico

14 Informant (Address): Mrs. Louisa Cox JOHNS HOPKINS HOSPITAL

15 Filed AUG 9-1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-8- 1923

17 I HEREBY CERTIFY, That I attended deceased from July 31, 1923, to August 8, 1923, that I last saw him alive on August 8, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis of liver (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 1-1923

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) F. H. Reichert, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mexico City-Mexico

DATE OF BURIAL: Aug 10 1923

20 UNDERTAKER: John O. Mitchell

ADDRESS: 120 W. Fayette

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78200

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D78200

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2623 Dulaney ST., 70 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John G Gempman

(a) RESIDENCE NO. 2623 Dulaney ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Annie E Gempman

6 DATE OF BIRTH (month, day, and year): May 14 1862

7 AGE: Years 61 Months 2 Days 23 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Chas. Gempman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emma Schuesbeck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Chas Gempman

(Address): Hayward Baltimore

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 27 1923

17

I HEREBY CERTIFY, That I attended deceased from August 25, 1923, to August 27, 1923, that I last saw him alive on August 27, 1923, and that death occurred, on the date stated above, at 1 PM.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Uraemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Rupert D Dean, M. D.

(Address) 1209 Mass Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 30 1923
20 UNDERTAKER	ADDRESS
Harry H. Witzke	1531 W. Pratt St

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

869-1923

Spec.—1-10-21—M&T—1500 Blks.

D78201

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78201

CERTIFICATE OF DEATH.

143-002

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Green ST., S 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leona Cord.

(a) RESIDENCE No. 2015 Robb ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George J. Cord.

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) Aberdeen Md (State or country)

PARENTS

10 NAME OF FATHER See W. Godwin

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Emma Sims

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant George J. Cord.

(Address) 2015 Robb St.

15 Filed AUG 10 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1923

17

I HEREBY CERTIFY, That I attended deceased from 7-29, 1923, to 8-9, 1923, that I last saw her alive on 8-9-1923, 19 and that death occurred, on the date stated above, at 10:5-2pm.

The CAUSE OF DEATH* was as follows:

Rupture of Ectopic pregnancy (Right side)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Ectopic pregnancy Right side (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7-30-23

Was there an autopsy? no Clinical findings

What test confirmed diagnosis?

(Signed) R. Hayley Lee, M. D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Aberdeen Md.	Aug. 11 1923.
20 UNDERTAKER Wm. J. Tichnor Sons	ADDRESS North Penna Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78202

CERTIFICATE OF DEATH.

71-001

D78202

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2525 Francis St. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie E Dunn

(a) RESIDENCE NO. 2525 Francis St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 27/20

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	—	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Thomas Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pikesville Md

12 MAIDEN NAME OF MOTHER Estelle Seabrease

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Thomas Dunn

(Address) 2525 Francis St

15 Filed AUG 10 1923 ROBERT A. KRAMER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 5, 1923, to Aug 8, 1923.

that I last saw h.er alive on Aug 7, 1923.

and that death occurred, on the date stated above, at 5A m.

The CAUSE OF DEATH* was as follows:

Cerebral Meningitis

(duration) — yrs. — mos 3 ds.

CONTRIBUTORY (Secondary) Nasal infection

(duration) — yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal Examination

(Signed) Edw Talbott, M. D.

Aug 5, 1923 (Address) 1353 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Aug 10 1923

20 UNDERTAKER Martin Luke & Sons — ADDRESS 1827 W North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78203

CERTIFICATE OF DEATH.

161-001 D78203

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3718 E. Lombard St. St. 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Paul H. Heck

(a) RESIDENCE. No. 3718 E. Lombard St St., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 9-1923.

7 AGE	Years	Months	Days	If LESS than 1 day 4 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Adolph Heck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Bertha Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Adolph Heck
(Address) 3718 E. Lombard St.

15 Filed AUG 10 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1923, to Aug 9, 1923, that I last saw him alive on Aug 9, 1923, and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. 8 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. S. Linden M. D.

8/11, 1923 (Address) 3236 E. Pratt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem. Woodlawn Cem.	Aug 10 1923
20 UNDERTAKER Lilly & Fiske	ADDRESS 503 N. Gay St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78204 ✓ D78204

109-082

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3000 Baker St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary W. Fischer

(Residence in Baltimore: No. 3000 Baker St. St.; 69 yrs. 1 mos. 22 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, June (Month) 17 (Day), 1854 (Year)

7-AGE, 69 yrs. 1 mos. 22 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... House-wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Frank Bauer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catherine Schriener

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Wm. L. Smith

(Address) 3000 Bakers St.

15-

Filed AUG 10 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 9 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 10 1923, to Aug 9 1923, that I saw her alive on Aug 9 1923, and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH was as follows:

Acute Endocarditis

(Duration) ....yrs. ....mos. 9 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) O. O. Lloyd M. D.

Aug 9, 1923 (Address) 733 Eutaw St

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, New Cathedral Cemetery — DATE OF BURIAL, Aug 11, 1923

20-UNDERTAKER Elmer W. Conklin — ADDRESS 924 E. Eager St.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec. 6-9-19 H. P. Co.—1000 Bks.

D78205

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002
D78205

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 N Post St ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry Kirk Roberts Jr

(a) RESIDENCE. No. 1611 N Post St ST., 8 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? —— yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 9 1923

7 AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. or min.
—	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Harry Kirk Robert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherine E Roeder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Harry Kirk Robert
(Address) 1611 N Post St

15 Filed AUG 10 1923, 19 ROBERT R. KRAMER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9th 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 9, 1923, to Aug 9, 1923, that I last saw h[illegible] alive on Aug 9, 1923, and that death occurred, on the date stated above, at 5 9. m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H Herzog MD M. D.

Aug. 19 23 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 10 1923
20 UNDERTAKER	ADDRESS
Johannah Charles	1004 Aisquith St

A. 15.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Heart.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78206

D78206

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Marlborough Apt.

CITY OF BALTIMORE: (No. Eutaw Place & Wilson ST., 14th WARD)

2-FULL NAME Amanda Octavia Leber

(a) RESIDENCE No. Marlborough Apt. ST., 14 WARD (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 8 mos. 6 ds. How long in U. S., if of foreign birth? 74 yrs. 8 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Frank Leber

6 DATE OF BIRTH (month, day, and year): Nov. 2-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: William Fuller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bltimore Md.

12 MAIDEN NAME OF MOTHER: Amanda M Wolfe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: William F Leber (Son)
(Address): Marlborough Apt.

15 Filed AUG 10 1923 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 8 1923

17 I HEREBY CERTIFY, That I attended deceased from June 3 1923, to Aug 8 1923,
that I last saw her alive on Aug 8 1923,
and that death occurred, on the date stated above, at 11.20 A m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis + Angina Pectoris

(duration) about 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiplegia, L. + R. paralysis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Robert W. Mifflin, M. D.

Aug 9. 1923 (Address) 1016 Madison Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Aug 10 1923

20 UNDERTAKER: STEWART & MOWEN COMPANY

ADDRESS: 128 W. NORTH AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Domkowski

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78207

CERTIFICATE OF DEATH.

1/13

D78207

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2639 Fait Ave ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Domkowski

(a) RESIDENCE NO. 2639 Fait Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 10 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Adam Domkowski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Mary Nowakowski

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Adam Domkowski (Address) 2639 Fait Ave

15 Filed ..... 19 ..... Registrar

ROBERT A. KRAUTER

AUG 10 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1923, to Aug 9, 1923.

that I last saw he alive on Aug 9, 1923,

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Enteric Collapse

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) ..... yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Kramer M. D.

(Address) 1200 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cem.	Aug 10 1923
20 UNDERTAKER	ADDRESS
S G Trautman	1000 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78208

CERTIFICATE OF DEATH.

113 ✓ D78208

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 914 S. Charles St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gilbert L. Lehmyre

(a) Residence No. 914 S. Charles St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) \

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of \

6-DATE OF BIRTH (month, day and year) July 15-22

7-AGE. 1 yrs. mos. 23 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work \
(b) General nature of industry, business, or establishment in which employed (or employer) \
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Balto

PARENTS.

10-NAME OF FATHER. John E Lehmyre

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto

12-MAIDEN NAME OF MOTHER. Blanche Chambers

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

14- (Informant) John E. Lehmyre
(Address) 914 S. Charles St

15- Filed AUG 10 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 9/23

17- I HEREBY CERTIFY, That I attended deceased from July 20 19 23 to Aug 9 19 23 that I last saw h.. alive on Aug 8 19 23 and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? \

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) L. C. Campbell M. D.

Aug 9. 1923 (Address) 1644 Hanover St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park Cemetery	Aug 11 1923.
20-UNDERTAKER.	ADDRESS
F. H. Krance & Son	763 Hanover St

SHOULD be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks. 78209

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D 8209

REGISTERED NO. D 8209

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John P. Webster

(a) RESIDENCE NO. Aberdeen Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 14 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	15			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John S. Webster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Pinkerton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs J S Webster

(Address) Aberdeen R F D

15 Filed AUG 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 5 1923 to Aug 10 1923, that I last saw h alive on Aug 10 1923, and that death occurred, on the date stated above, at 11:50 a m.

The CAUSE OF DEATH* was as follows:

Cavernous Sinus thrombosis, bilateral

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. B. Price, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catonsville Md

DATE OF BURIAL Aug 13 192

20 UNDERTAKER Howard K McKenna

ADDRESS Aber

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

78211 D78210 — 113 D78210

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 S. Fremont ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emmanuel H. Marcake

(Residence in Baltimore: No. 601 S. Fremont ave St.; ..... yrs.. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	

6-DATE OF BIRTH, Oct 16 (Month), ... (Day), 1922 (Year)

7-AGE, ... yrs. 10 mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Nicholas Marcake

11-BIRTHPLACE OF FATHER (State or Country), Greece

12-MAIDEN NAME OF MOTHER Pomplis

13-BIRTHPLACE OF MOTHER (State or Country), Greece

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. M. Pomplis

(Address) 2023 Payson St

15- AUG 11 1923 ROBERT A. KRAUTER, Registrar.
Filed ....., 191.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month), 10th (Day), 1923 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Aug. 1st 1923, to Aug. 10th 1923, that I saw him alive on Aug. 8th 1923, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Entero-colitis

..... (Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. W. H. Offutt M. D.

8-10-23, 1923 (Address) 3402 Wallbrook Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. Is the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Woodlawn Cem	Aug. 11, 1923
20-UNDERTAKER Robert Brookover	ADDRESS Cor Calhoun & Franklin Sts

N.B.—Every item of information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78211

CERTIFICATE OF DEATH.

D78211

139

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. WARD)

2-FULL NAME Kate Kahmann

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1033 N. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Karl Kahmann

6 DATE OF BIRTH (month, day, and year): April 25th 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Car cleaner

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: W. R. R.

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Kate Knapp

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Wm Kahmann

(Address) 2112 Cambridge St.

15 Filed AUG 17 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 10 1923.

17 I HEREBY CERTIFY, That I attended deceased from August 3, 1923, to August 10, 1923,

that I last saw him alive on August 10, 1923

and that death occurred, on the date stated above, at 7:40 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. sign.

(Signed) [illegible] M. D.

. 19 (Address) St. J. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Swartzs

DATE OF BURIAL: Aug 13th 1923

20 UNDERTAKER: Martin Dippel

ADDRESS: 37 S. Conn

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78212

1923 D78212

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1629 Gough ST.) (WARD) 3

2-FULL NAME Rosa Aquino

(a) RESIDENCE NO. 1629 Gough ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Aquino

6 DATE OF BIRTH (month, day, and year): 1845

7 AGE: Years 78 Months Days If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Vincent Raba

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Mary Raba

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Domonick Aquino

(Address) 1629 Gough St

15 Filed AUG 11 1923, 19... Registrar

ROBERT A. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 23rd 1923, to Aug 8th, 1923.

that I last saw h[illegible] alive on Aug 8th, 1923.

and that death occurred, on the date stated above, at 5 a.m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Fracture of right shoulder right hip

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X. Ray

(Signed) William Deb, M. D.

, 19 (Address) 1742 Woodland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer.

DATE OF BURIAL: Aug 11th 1923

20 UNDERTAKER: Martin W. E. Dippel

ADDRESS 378 Lanvale St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

1942 Moreland Ave

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as to kind of labor. *Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY, and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accidental fall from
2 stair

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78213

CERTIFICATE OF DEATH.

90 D78213

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 W. Belvidere Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Frederick Rohwig

(Residence in Baltimore: No. 202 W. Belvidere Ave St.; 5 yrs. mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Oct (Month) 9 (Day) 1863 (Year)

7-AGE, 59 yrs. 10 mos. 0 ds. | If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired Grocer
(b) General nature of industry, business, or establishment in which employed (or employer): —

9-BIRTHPLACE, (State or Country), Anne Arundel Co Md

PARENTS.

10-NAME OF FATHER, John C Rohwig

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Catharine Ell

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Rohwig

(Address) 202 W. Belvidere Ave

15- AUG 11 1923 ROBERT R. KRAUTER, Registrar.

Filed....., 191.... Burial Permit No.....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 9 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 7 1923, to Aug 9 1923, that I saw him alive on Aug 7 1923, and that death occurred, on the date stated above, at 12.05 A.M.

The CAUSE OF DEATH* was as follows:

Auricular Fibrillation

(Duration) over yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(Duration) Unknown yrs. mos. ds.

(Signed) J. W. Downes M. D.

Aug 9, 1923 (Address) 5016 Park Heights Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Ivy Hill Cem. Laurel | DATE OF BURIAL, Aug 12, 1923

20-UNDERTAKER E Schlosser Son | ADDRESS 1039 Thames St

Cannon.

91-02

Spec.—6-9-19—H. P. Co.—1000 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78214

D78214

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 941 S. Luzerne Av. 5 WARD)

2-FULL NAME Rachel Cannon

(a) RESIDENCE. NO. 1124 Thompson ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Cannon

6 DATE OF BIRTH (month, day, and year) May 1-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Leaford Del

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Alice Washington

(Address) 941 S. Luzerne Av

15 Filed ..... 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 3 1923 to Aug 8 1923

that I last saw her alive on Aug 8 1923

and that death occurred, on the date stated above, at 11.40 A m.

The CAUSE OF DEATH* was as follows:

Arteio Sclerosis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Reggelge

(Signed) H. G. Leuk M. D.

Aug 8 (Address) North Ave & Dime

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	8/11 19 23
20 UNDERTAKER	ADDRESS
Jas Smith	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78215

CERTIFICATE OF DEATH.

113

D78215

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 451 N. Robinson ST., 6 WARD)

2-FULL NAME Emma M. Winkelman

(a) RESIDENCE NO. 457 N. Robinson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Frederick Winkelman

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Muriel L. Waller

13 BIRTHPLACE OF MOTHER (city or town) Maryland (State or country)

14 Informant Frederick Winkelman (Address) 457 N. Robinson St

15 Filed AUG 11 1923 Registrar ROBERT A. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 8 1923

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1923, to Aug 8, 1923, that I last saw her alive on Aug 8, 1923, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows: Gastro-Enteritis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. E. Heaver M. D.

8/10 1923 (Address) 394 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chance Somerset Co. Md. DATE OF BURIAL Aug 11 1923

20 UNDERTAKER H. Sander Sons ADDRESS 1710 Eutaw St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78216

CERTIFICATE OF DEATH.

90 D78216

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 823 N. Bradford ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Rezac

(a) RESIDENCE NO. 823 N. Bradford ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. 11 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barbara Rezac

6 DATE OF BIRTH (month, day, and year): Aug 28/1846

7 AGE: Years 76 | Months 11 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Jos. Rezac

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant (Address): Mrs. Barbara Rezac 823 N. Bradford

15 AUG 11 1923 ROBERT R. KRAMER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-7-1923

17

I HEREBY CERTIFY, That I attended deceased from June 1 23 to Aug 7 19 23

that I last saw him alive on Aug 7 19 23

and that death occurred, on the date stated above at 2 P. m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. J. Reese M. D.

19 (Address) 100 N. Bradford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill Cem.

DATE OF BURIAL: Aug. 11 1923

20 UNDERTAKER: Jos. J. Merz

ADDRESS: 156 N. Eutaw ave

FILMED

D78217

14001 78217

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 Myrtle Ave ST. 17 WARD)

2-FULL NAME Celeste Henry

(a) RESIDENCE. No. 1207 Myrtle Ave ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col	married

5a If married, widowed, or divorced
HUSBAND of ~~(or WIFE) of~~ Addie Henry

6 DATE OF BIRTH (month, day, and year) July 9 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bootblack & ...

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Maria Henry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Celeste Henry
(Address) 1207 Myrtle Ave

15 Filed ..., 19... ROBERT A. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1923, to Aug 5, 1923, that I last saw him alive on Aug 5, 1923, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Diagnosis

(Signed) Frank E. Wagner, M. D.

8/9, 1923 (Address) 1056 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Md

DATE OF BURIAL 9/11 1923

20 UNDERTAKER ...

ADDRESS ...

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DARK STAIN

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78218

CERTIFICATE OF DEATH.

74001 D78218

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 310 S. Bethel ST.: 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Addie Williams

(a) RESIDENCE. No. 310 S. Bethel ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 14, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John Bonds

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Annie Benett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Florance Williams

(Address) 310 S Bethel st

15 Filed AUG 11 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9th 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug. 6th, 1923, to Aug 9th, 1923, that I last saw her alive on ....., 1923, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob L Ulmer, M. D.

8-9, 1923 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury	Aug 12 1923
20 UNDERTAKER	ADDRESS
John W Henderson	1602 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78219

CERTIFICATE OF DEATH.

45 D78219

1-PLACE OF DEATH

Registered No. 6

City of BALTIMORE: (No. Municipal Hospital. St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Gorman

(a) Residence No. 1520 Riggs Ave. St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1887

7-AGE. 36 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housework

(b) General nature of industry, business, or establishment in which employed (or employer). 070

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Hartford Co., Md.

PARENTS.

10-NAME OF FATHER. Thomas Griffin

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore, Md.

12-MAIDEN NAME OF MOTHER. Harriet Banks

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Hartford Co., Md.

14- (Informant) Municipal Hospital Records

(Address)

15- Filed AUG 11 1923 ROBERT A. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) August 9, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 30 19 23 to August 9 19 23

that I last saw her alive on August 9 19 23

and that death occurred, on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma (Rectum)

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Fulton M. D

8-9- 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Leakin Park DATE OF BURIAL. Aug 11 19 23

20-UNDERTAKER. Jas. A. Travis ADDRESS 1303 Pine St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78220

CERTIFICATE OF DEATH.

31 D78220

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 830 China ST.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Cooper

(a) RESIDENCE. No. 830 China ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem.	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Cooper

6 DATE OF BIRTH (month, day, and year) Jan. 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43 yrs.	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co. Md.

PARENTS

10 NAME OF FATHER Daniel Stennard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent Co. Md.

12 MAIDEN NAME OF MOTHER Priscilla Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co. Md.

14 Informant Samuel Cooper (Address) 830 China St.

15 Filed AUG 11 1923, 19.. ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10" 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15" 1923, to Aug. 10" 1923 that I last saw h alive on Aug 10" 1923 and that death occurred, on the date stated above, at 7:40 P m.

The CAUSE OF DEATH* was as follows:

Acute Pleuritis (Tuberculous)

Duration yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. L. Shelton, M. D.

8/10/23 (Address) 30 3 W. Hamburg St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Aug 13 1923

20 UNDERTAKER John H. Lewis & Bro. ADDRESS 303 W. Baltimore St.

N. B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78221

CERTIFICATE OF DEATH.

10. D78221

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital, 20 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME anita Puepke

(a) RESIDENCE NO. 2646 Dulaney ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 23-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER Lee Puepke

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER Eliza Pennington

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant (Address) Lee Puepke 2646 Dulaney St.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1923, to Aug 10, 1923, that I last saw her alive on Aug 10, 1923, and that death occurred, on the date stated above, at 3:30 a.m.

The CAUSE OF DEATH* was as follows:

Diphtheria, nasal, tonsilla, pharyngeal & laryngeal

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) — yrs. — mos. 5+ ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? culture (+)

(Signed) B MacSwain, M. D.

8/10/1923 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Aug 11. 1923

20 UNDERTAKER: C. W. Dill — ADDRESS 309 Fredk. Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78222

CERTIFICATE OF DEATH.

49 D78222

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2103 Walbrook Av ST. 15 WARD)

2-FULL NAME Mrs Elizabeth Mc Govern

(a) RESIDENCE NO. 2103 Walbrook Av ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of David Joseph Mc Govern

6 DATE OF BIRTH (month, day, and year) Oct 28 - 1858

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Alvin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Jane Elliott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant James Alvin McGovern
(Address) 2103 Walbrook Ave

15 Filed ..... , 19 ..... MTP Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec-13 , 1922 , to Aug-10 , 1923 .
that I last saw her alive on Aug-10 , 1923 .
and that death occurred, on the date stated above, at 12-30 a m.
The CAUSE OF DEATH* was as follows:

Carcoma of Sternum

(duration) yrs. 8 mos ... ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No —

What test confirmed diagnosis? None

(Signed) E. Gill Hall M. D.

, 19 (Address) 1631 E. North Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bonnie Brae Cemetery — DATE OF BURIAL Aug 13 1923

20 UNDERTAKER Wilbur W Skinner — ADDRESS 1018 Edmondson Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78223

113 D78223

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 S. Linwood Ave ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilbut G. Hartman

(a) RESIDENCE. No. 515 S. Linwood Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single.

5a If married, widowed, or divorced
BUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21-1923.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 0d0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER George Hartman

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Maria Stez.

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant George Hartman
(Address) 515 S. Linwood Ave.

15 Filed AUG 11 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1923

17 I HEREBY CERTIFY, That I attended deceased from 8/9, 1923, to 8/9/23, 19, that I last saw he alive on 8/9/23, 19, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Gastro enteritis!

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Catherine Schneider, M. D.

8/10, 1923 (Address) 2939 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem.	Aug 11 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78224

CERTIFICATE OF DEATH.

1132

D78224

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 434 S Bond ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wiktor. Kosakowski

(a) RESIDENCE NO. 434 S Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 23 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Leon Kosakowski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Maryanna Dwornik

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Leon Kosakowski
(Address) 434 S Bond Street

15 Filed AUG 11 1923 ROBERT A. KRAUER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 10 1923

17

I HEREBY CERTIFY, That I attended deceased from aug 7 1923, to aug 10 1923,

that I last saw him alive on aug 10 1923,

and that death occurred, on the date stated above, at 845 P m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) A Ries, M. D.

Aug 11 1923 (Address) 24 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	aug 11 1923
20 UNDERTAKER	ADDRESS
John M Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78225

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D78225

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 S 14th ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maryanna Sobolewski

(a) RESIDENCE No. 2206 Cambridge ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Sobolewski

6 DATE OF BIRTH (month, day, and year) Feb. 2 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER James Nowak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John . Sobolewski

(Address) 2206 Cambridge Street

15 Filed AUG 14 1923 ROBERT R. KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1923

17 I HEREBY CERTIFY, That I attended deceased from August 5th, 1923, to August 10th, 1923, that I last saw her alive on August 10th, 1923, and that death occurred, on the date stated above, at 12.30 Pm.

The CAUSE OF DEATH* was as follows:

(Chronic diffuse nephritis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Heart failure & acute

(duration) yrs. mos 5 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Harry A Ambrose, M. D.

Aug 10, 1923 (Address) 1625 N Patterson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus — DATE OF BURIAL: Aug 15 1923

20 UNDERTAKER: John m Weber — ADDRESS: 1803 Bank

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78226

CERTIFICATE OF DEATH.

1137 D78226

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 S. Rose ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Leon Raczniak

(a) RESIDENCE. No. 618 S. Rose ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 13 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 28-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore. Md
(State or country)

PARENTS

10 NAME OF FATHER Peter Raczniak.

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Anna M. Kalita

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Peter Raczniak.
(Address) 618 S. Rose St.

15 Filed AUG 11 1923 ROBERT A. KRAUS Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11 — 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 9 —, 1923, to Aug 11 —, 1923, that I last saw him alive on Aug 11, 1923, and that death occurred, on the date stated above, at 12.40 A. m.

The CAUSE OF DEATH* was as follows:

Acute Ileo-Colitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Philibert Antignani M. D.

. 19 (Address) 2942 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	Aug 13. 1923
20 UNDERTAKER	ADDRESS
M. F. Sadowski.	705 S. Ann

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78227

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1291 D78227

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1611 Lancaster ST., 2 WARD)

2-FULL NAME James J. Winowska

(a) RESIDENCE NO. 1611 Lancaster ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Winowska

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rope Layer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER Frank Winowska

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Magdalena Kolodziejczak

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14
Informant Mrs. Anna Pintowska
(Address) 1611 Lancaster St.

15
Filed ... 19...
Registrar

AUG 11 1923
ROBERT R. KRAUTER,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 10 1923

17
I HEREBY CERTIFY, That I attended deceased from July 5th, 1923, to August 10, 1923,
that I last saw him alive on August 7-23,
and that death occurred, on the date stated above, at 8 a.m.
The CAUSE OF DEATH* was as follows:

(Chronic Myocarditis
Arterio Sclerosis
Chronic Nephritis

(duration) yrs. 11 mos ds.

CONTRIBUTORY (Secondary) Uremic Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Jos. J. Sadowski, M. D.

, 19 (Address) 705 S. Ann St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem.	Aug 13th 1923.
20 UNDERTAKER	**ADDRESS**
M. J. Sadowski.	705 S. Ann St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78228 — 113 — D78228

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 Union Ave ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joy Ruth Slate

(a) RESIDENCE No. 111 Union Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER William G. Slate

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md (State or country)

12 MAIDEN NAME OF MOTHER Pearl Meyers

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant William G. Slate (Address) 111 Union Ave.

15 Filed AUG 11 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 9th, 1923, to Aug 9th, 1923, that I last saw her alive on Aug 9th, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) L. L. Gordy M. D.

8-10, 1923 (Address) #218 Harford Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Loudon Park — Aug 11 1923

20 UNDERTAKER — ADDRESS

Harry H. Witzleb — 1534 W. Lombard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY: PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D78229

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5-002

5-D78229 Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1209 N. Mooch St. 14 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Oppenheim

(Residence in Baltimore: No. 1209 N. Mooch Ave St.; yrs. Lifetime ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female | 4-COLOR OR RACE, White | 5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH Dec 28 1870 (Month) (Day) (Year)

7-AGE 52 yrs. 7 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION: (a) Trade, profession, or particular kind of work Teacher (b) General nature of Industry, business, or establishment in which employed (or employer) 068

9-BIRTHPLACE, (State or Country) Balto. City

PARENTS:

10-NAME OF FATHER Jacob Oppenheim

11-BIRTHPLACE OF FATHER, (State or Country) Germany

12-MAIDEN NAME OF MOTHER Hanna Levy

13-BIRTHPLACE OF MOTHER, (State or Country) Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Oppenheim

(Address) 1209 N Mooch Ave

15- AUG 11 1923 ROBERT R. KRAUTER Burial Permit Clerk. 193.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Aug 10 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, and from autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: A Paralysis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. ds.

(Signed) H. C. Blades M. D. (Coroner.)

(Address) 1433 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Chot Sholam Cem. DATE OF BURIAL. Aug 13" 19 23

20-UNDERTAKER L. Bondheim ADDRESS 1130 Park Royal Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78230

CERTIFICATE OF DEATH.

3 / D78230

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 516 N Pearl ST., 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella May Preston-Cox

(a) RESIDENCE NO. 676 N Pearl ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (~~HUSBAND of~~ or) WIFE of Robert Cox

6 DATE OF BIRTH (month, day, and year) May 25, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hartford County Md

PARENTS

10 NAME OF FATHER Samuel Preston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hartford County Md

12 MAIDEN NAME OF MOTHER Rachel Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hartford County Md

14 Informant Robert Cox (Address) 516 N Pearl St

15 AUG 11 1923 ROBERT R. KRAMES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 7 — 1923

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1923, to Aug 8, 1923, that I last saw her alive on Aug 7, 1923, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) Indeterminable

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) D Howell M. D.

(Address) 629 Carroll Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Rest Cem — DATE OF BURIAL 8-11-1923

20 UNDERTAKER Daniel Easton — ADDRESS 816 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D78231

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78231

CERTIFICATE OF DEATH.

112

1-PLACE OF DEATH

City of BALTIMORE: (No. 1723-E. 33rd St., 9 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Chas Brown

(Residence in Baltimore: No. 1723-E-33rd St. (yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. October (Month) 19 (Day) 1880 (Year)

7-AGE. 42 yrs. 9 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. accountant
(b) General nature of industry, business, or establishment in which employed (or employer) Standard Oil Co

9-BIRTHPLACE, (State or Country). N. J.

PARENTS.

10-NAME OF FATHER. Chas Brown

11-BIRTHPLACE OF FATHER, (State or Country). N. J.

12-MAIDEN NAME OF MOTHER. Mary J Dunn

13-BIRTHPLACE OF MOTHER, (State or Country). Penna.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie Brown.

(Address) 1723 E. 33rd St.

15- Filed AUG 11 1923 ROBERT R. KRAUSER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug. (Month) 9 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ac Gastritis
Ac Dil Stomach

(Duration) yrs. 5 mos. 6 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo A Wades M. D.
(Coroner)
(Address) 4 E Saratoga

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Druid Ridge DATE OF BURIAL. Aug 11th 1923.

20-UNDERTAKER. John A. Moran ADDRESS 300 E Baltimore St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLA

Spec.—8-24-14—M. & T.—2000 Bks.

D78232

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5-47 D78232

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 207 Aisquith ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Eliza A Wheeler

(Residence in Baltimore: No. 207 Aisquith St St.; 30 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widowed

6-DATE OF BIRTH, Unknown (Month) (Day), 1850 (Year)

7-AGE, Appox 73 yrs yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)..... 070

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Robert A Elliott Jr wife

(Address) 1725 Ashland Ave

15- AUG 11 1923 Filed....., 191.... ROBERT K. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 9 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Feb 1923, to Aug 9 1923, that I saw her alive on Aug 8 1923, and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast.

(Duration)....yrs. 7 mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration)....yrs.....mos.....ds.

(Signed) R J Young M. D.

8/11, 1923 (Address) 1429 Eutaw

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....de. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Laurel Cemetery — DATE OF BURIAL, Aug 11. 1923

20-UNDERTAKER Mrs A E Elliott — ADDRESS 1725 Ashland Ave

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78233

CERTIFICATE OF DEATH.

1916 1-001 D78233

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Maternity ST.; 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Elizabeth Brauer

(Residence in Baltimore: No. West End Maty Hospital St.; 4 yrs.. mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	white	

6-DATE OF BIRTH, July 30 (Month) 23 (Day) 1 (Year)

7-AGE, ...yrs. 12 mos. ....da. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), West End Maty Hospt

PARENTS.

10-NAME OF FATHER, Charles Brauer

11-BIRTHPLACE OF FATHER (State or Country), Va.

12-MAIDEN NAME OF MOTHER Stella Koch.

13-BIRTHPLACE OF MOTHER (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. Koch

(Address) 1 Balto.

15- Filed AUG 11 1923, 191... ROBERT B. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 10 (Month) 23 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 30 1923, to Aug 10 1923, that I saw h[illegible] alive on Aug 10 1923, and that death occurred, on the date stated above, at 2.20 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary) .....

(Duration) ....yrs. ....mos. ....da.

(Signed) B. P. Sherman M. D.

....., 191... (Address) Sparks Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Baltimore Cem.	....., 1923
20-UNDERTAKER Wm Cook	ADDRESS 602 E North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

1729 N. Lombard.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78234

CERTIFICATE OF DEATH.

129 D78234

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 Pine Heights Terrace ST. 25 WARD)

2-FULL NAME Lester Eberle Edmonds

(a) RESIDENCE No. 9 Pine Heights Terrace ST. Fiddler's Hill WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa Frances

6 DATE OF BIRTH (month, day, and year) July 23 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	54		18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst. Mngr. 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Ryland Edmonds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Agnes Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Agnes Edmonds (Address) 9 Pine Heights Ter.

15 Filed AUG 11 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10 1923

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1923, to Aug 10, 1923, that I last saw him alive on Aug 10, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Chronic Nephritis (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No Physicians Certificate

What test confirmed diagnosis? Clinical Symptoms

(Signed) James F. Broughton M. D.

8/11. 1923 (Address) 1729 N. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Aug. 13 1923 — DATE OF BURIAL

20 UNDERTAKER Wm Cook & Sons — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78235 HEALTH DEPARTMENT—CITY OF BALTIMORE D78235

CERTIFICATE OF DEATH. 84

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. 1439 E. Fook Ave St. 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Eugene B. Brady.

(Residence in Baltimore: No. 1439 E Fook Ave St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male 4-COLOR OR RACE White 5-CONDITION Married (Single, Married, Widowed, or Divorced. (Write the word.)

6-DATE OF BIRTH, Sept 9 1864 (Month) (Day) (Year)

7-AGE. 58 yrs. 11 mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION: (a) Trade, profession, or particular kind of work Blacksmith. (b) General nature of industry, business, or establishment in which employed (or employer) 006

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, Eustes Brady

11-BIRTHPLACE OF FATHER, (State or Country) Maryland

12-MAIDEN NAME OF MOTHER, Elanor Burrin

13-BIRTHPLACE OF MOTHER, (State or Country) Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Brady

(Address) 1439 E. Fook Ave

15- Filed AUG 11 1923 ROBERT P. KRAUTER, Burial Permit Clerk, Registrar.

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH, Aug 10 23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest and Autopsy find that said deceased came to death (Autopsy or Inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

A Angina Pectoris

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

(Signed) C. E. Hailes M. D.

(Coroner.)

(Address) 1423 N Bro

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. W K Oliver Cem Aug 13th 23

UNDERTAKER. ADDRESS

W B Cook 502 E North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78236

100-001

CERTIFICATE OF DEATH.

REGISTERED NO. D78236

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob H. Diller

(a) RESIDENCE NO. 14 N. Gilmor ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma J. Diller

6 DATE OF BIRTH (month, day, and year): Aug 5 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist 631

(b) General nature of industry, business, or establishment in which employed (or employer): Railroad machinist

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: Peter Diller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa-

12 MAIDEN NAME OF MOTHER: Katherine Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Hospital Records

(Address): 1532 N. Broadway

15 Filed: AUG 11 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug-11 19 23

17 I HEREBY CERTIFY, That I attended deceased from June 6 - , 19 23, to Aug 11 - , 19 23,

that I last saw him alive on Aug-11 , 19 23

and that death occurred, on the date stated above, at 10.15 a. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia -

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hypertrophied Prostate Senile Gangrene-left leg (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug-3 '23

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) R. J. Plyler M. D.

, 19 (Address) University Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Aug 13 1923
20 UNDERTAKER	ADDRESS
George J. Smith	Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78237

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78237

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 724 Euclid Ave ST., 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Creney Sheppard

(a) RESIDENCE NO. 724 Euclid Ave ST., RP WARD 9th

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Jos. T. Sheppard

6 DATE OF BIRTH (month, day, and year): April 11, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Wm T. Creney.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizabeth Tiffen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hartford Balto Co Md

14 Informant (Address): John D. Creney 724 Euclid Ave

15 Filed AUG 11 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 10 1923

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1923, to August 10, 1923, that I last saw her alive on August 10, 1923, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

some years (duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary): Uraemia.

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Sydney R Miller, M. D.

, 19 (Address) 900 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Aug 13 1923

20 UNDERTAKER: Jno B Spence. — ADDRESS: 1325 N Caroline St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78238

CERTIFICATE OF DEATH.

90 D78238

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 873 St. Johns Court St. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Green alias Thos. Young

(Residence in Baltimore: No. 873 St. Johns Court St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	black	widower

6-DATE OF BIRTH, unknown (Month) (Day) 1..... (Year)

7-AGE,	If LESS than 1 day,
36 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Rag- picker
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), "

12-MAIDEN NAME OF MOTHER, "

13-BIRTHPLACE OF MOTHER, (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Georgia Strother

(Address) 834 Coke Alley

15- Filed AUG 11 1923 Burial Permit Clerk. ROBERT R. KRAUTER, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 1/23 (Month) (Day) 192.... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac Dilatation

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) unknown (found dead in bed)

(Duration) yrs. mos. ds.

(Signed) J. S. Pullen M. D. (Coroner)

8/8/23 192.... (Address) 508 E. North Ave.

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL. ..... 19....
20-UNDERTAKER.	ADDRESS

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78239 — 101-091 — D78239

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Thos Byrnes

(Residence in Baltimore: No. Not known St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	

6-DATE OF BIRTH.

..... (Month) ..... (Day) ..... 1..... (Year)

7-AGE. 50 about yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... 687

9-BIRTHPLACE, (State or Country).

PARENTS.

10-NAME OF FATHER.

11-BIRTHPLACE OF FATHER. (State or Country).

12-MAIDEN NAME OF MOTHER.

13-BIRTHPLACE OF MOTHER. (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant).....

(Address).....

15- Filed ..... 192.. ROBERT R. KRAUTER, Registrar.

Hospital Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug 4 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Yes death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (Duration) Yrs. mos. 1 ds.

(Signed) G. E. Blades M. D.

(Coroner.)

Aug 9 1923 (Address) 432 E Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. ..... 19....

20-UNDERTAKER. Commissioner Health. ADDRESS

N. B—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNIVERSITY OF MARYLAND AUG 11 1923 MEDICAL LIBRARY

D78240

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78240

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — City of BALTIMORE: (No. Jones Falls at Pratt St., 4 Ward) — Registered No. C 182

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME "Lambdin"

(Residence in Baltimore: No. Not known St.; yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	

6-DATE OF BIRTH. ..... 1..... (Month) (Day) (Year)

7-AGE, 40 about- ..... yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country).

PARENTS.

10-NAME OF FATHER,

11-BIRTHPLACE OF FATHER, (State or Country).

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country).

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15- Filed ..... 192.....

AUG 11 1923 ROBERT R. KRAUSE, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 2 25
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Res death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning

(Duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Clinton Lloyd M. D.
(Coroner)

Aug 2 192 (Address) 123 St Paul

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL 19

20-UNDERTAKER, ADDRESS

UNIVERSITY OF MARYLAND
Commissioner of Health
AUG

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78241

CERTIFICATE OF DEATH.

38 D78241

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST. No WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Gooden

(a) RESIDENCE NO. Bay View Asylum. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): 1877

7 AGE: Years: 45 Months: Days: If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Municipal Hospital Records.

(Address)

15 Filed AUG 11 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 6, 1923

17

I HEREBY CERTIFY, That I attended deceased from May 8, 1915, to August 6, 1923, that I last saw her alive on August 6, 1923, and that death occurred, on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Syphilis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchio-Pneum. (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude S. Hudson, M. D.

8-7, 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health. AUG 9 1923

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78242

CERTIFICATE OF DEATH.

D78242

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 3801 Conduit St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Julia Emerson

(Residence in Baltimore: No. 3801 Conduit St St.; yrs. 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX F

4-COLOR OR RACE, White

5-Single, Married, ~~Widow~~ or ~~Divorced~~, (Write the word.) Widow

6-DATE OF BIRTH, Dec 25 1846 (Month) (Day) (Year)

7-AGE, 76 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer)..... None

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (State or Country) Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (State or Country) Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

Christina Baldwin

3801 Conduit ave

(Address)

15- FILED AUG 11 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 10 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries from a fall

Accidental

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) A

(Duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D. (Coroner.)

1923 (Address) 362 Roland Ave

*Give the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Laurel Md DATE OF BURIAL. Aug 11 1923

20-UNDERTAKER. Ebenezer Sherwood ADDRESS Chestnut

Spec.—1-10-21—M&T—1500 Bks.

165581
D78243

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 33 ✓ D78243

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 19 WARD)

2-FULL NAME Samuel Carter.

(a) RESIDENCE No. 515 Parish St. City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widowed.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ James Carter (son).

6 DATE OF BIRTH (month, day, and year) — 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Carter.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Handy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address)

15 Filed AUG 14 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 9 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 6, 1923, to Aug 9, 1923, that I last saw him alive on Aug 9, 1923, and that death occurred, on the date stated above, at 4:50 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis

(duration) 0 yrs. 8-9 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Chas. W. Cumming M. D.

8/14/1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dorsey Whf Lincoln Va — DATE OF BURIAL Aug 12, 1923

UNDERTAKER Sam'l W. Chase & Son — ADDRESS 1400 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78244

D78244

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1012 Rutland Ave ST., 7 WARD)

2-FULL NAME Catherine M. Wright

(a) RESIDENCE No. 1012 Rutland Ave ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. — mos. — ds. How long in U. S., if of foreign birth? 68 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of: Mr Late George H. Wright

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE: Years 69 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Janitress at

(c) Name of employer: United Police Station

9 BIRTHPLACE (city or town) (State or country): Washington D. C.

PARENTS

10 NAME OF FATHER: Richard Rountree

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Rebecca Browning

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mrs. Frank J. Corrigan

(Address) 1012 Rutland Ave

15 Filed AUG 21 1923, 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 11 1923

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1923, to Aug 11, 1923, that I last saw her alive on Aug 10, 1923, and that death occurred, on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach, Ascites & Exhaustion

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma Stomach (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) O. O. Carman, M. D.

8-11-1923 (Address) 1707 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cemetery — DATE OF BURIAL: Aug. 14 19 23

20 UNDERTAKER: Henry Hoeck Son — ADDRESS: 1301 Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78245-6-3

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78245

CERTIFICATE OF DEATH.

X 113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vanessa Appel

(a) RESIDENCE NO. Wilna, Harford Co. Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Jan. 6-1923

7 AGE: Years —; Months 7; Days 4; If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: [illegible]

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Bertha Mayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Records

(Address)

15 Filed ..... , 19 ..... Registrar

AUG 12 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 11th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 19 23, to Aug 11th, 19 23, that I last saw her alive on Aug 11th, 19 23, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac Disease (Pulmonic stenosis with patent ductus Botalli)

(duration) yrs. Life mos. da.

CONTRIBUTORY (Secondary): Diarrhoeal (not dysentery)

(duration) yrs. 2 weeks mos. da.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) A. A. Weech, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wilna Harford Co. Md

DATE OF BURIAL: Aug 12 1923

20 UNDERTAKER: Wm. J. Tichnor & Son

ADDRESS: North & Pine

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78246

D78246

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3416 Myrtle Place ST.: 27 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Fritzler

(a) RESIDENCE. No. 3416 Myrtle Place ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 31-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Fritzler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Schmehling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address) John Fritzler 3416 Myrtle Place.

15 Filed AUG 12 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 1923, to Aug 10. 1923

that I last saw him alive on Aug 10. 1923.

and that death occurred, on the date stated above at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. F. Snyder M. D.

19 (Address) 800 N Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Aug. 17 1923
20 UNDERTAKER Lilly & Feiler	ADDRESS 403 S Wolfe St.

B.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78247

CERTIFICATE OF DEATH.

107 D78247

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2821 Ridgewood Ave ST., 15 WARD)

2-FULL NAME Hannah R Isear

(a) RESIDENCE NO. 2821 Ridgewood Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Isear

6 DATE OF BIRTH (month, day, and year) Unknown 1833

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	90	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Jack Lewis 1439 Eastern Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1923

17 I HEREBY CERTIFY, That I attended deceased from May 6 1923 to Aug 10 1923.

that I last saw her alive on Aug 10 1923

and that death occurred, on the date stated above, at 10 45 P m.

The CAUSE OF DEATH* was as follows:

Paralysis of Respiratory Centers

(Duration) — yrs. — mos — ds.

CONTRIBUTORY (Secondary) Senility

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank C. Hilliard, M. D.

8-10, 1923 (Address) 2636 Kate Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Herbert Franklin

DATE OF BURIAL 8-12, 1923

20 UNDERTAKER Jack Lewis 1439 Eastern Ave

ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

D78248

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D78248

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2100 E Balto ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Posner.

(a) RESIDENCE NO. 605 W. Balto st ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 38 yrs — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Nathan Fleishman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Eda Fleishman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant I H Fleishman

(Address) 1031 S Charles st

15 Filed AUG 12 1923, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 12 1923.

17

I HEREBY CERTIFY, That I attended deceased from May 16, 1923, to Aug 12, 1923.

that I last saw h[illegible] alive on Aug 12, 1923.

and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral embolism.
myocardial insufficiency

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ... Date of ...

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Edward L. Stone M. D.

, 19 (Address) 1810 E. Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cemetery — DATE OF BURIAL 8/12/23

20 UNDERTAKER L. Levinson & Bro — ADDRESS 1127 E Baltimore st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78249

CERTIFICATE OF DEATH.

124 D78249

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 Eutaw Place, ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Joseph Levi Straus,

(a) RESIDENCE NO. 1812 Eutaw Place, ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married,

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Florence Rayner Straus,

6 DATE OF BIRTH (month, day, and year) June 11th. 1849.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired,

(b) General nature of industry, business, or establishment in which employed (or employer) Brewer,

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Levi, Straus,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany,

12 MAIDEN NAME OF MOTHER Leona Marcus,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany,

14 Informant Mrs. Davis,
(Address) 1812 Eutaw Place.

15 Filed AUG 12 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11th. 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 3, 1923. to Aug. 11, 1923. that I last saw him alive on Aug. 10, 1923 and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Uraemia.
Myocardial Insufficiency.

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis. Sent.

(duration) 12 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual Lab. Tests.

(Signed) Joseph W. Kelsky, M. D.

(Address) 910 Brooks Lane.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Har Sinai. DATE OF BURIAL: Aug. 13th/23

20 UNDERTAKER: Harry Sondheim ADDRESS 1108 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item on this form should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1923 43 1880

D78250

CERTIFICATE OF DEATH.

139 D78250

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jessie Cox

(a) RESIDENCE NO. 1925 Brunt St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lindsey Cox

6 DATE OF BIRTH (month, day, and year) June 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43	[illegible]	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER Sandy Spears

11 BIRTHPLACE OF FATHER (city or town) (State or country) Louisiana

12 MAIDEN NAME OF MOTHER Hannah Spears

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Mrs. Gertrude Kearney (Address) 1637 Cottage Ave

15 Filed AUG 12 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 4, 1923, to Aug. 9, 1923, that I last saw her alive on Aug. 9, 1923, and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Fibroid Uterus

(duration) 6 yrs. mos. da.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes Date of 8-9-23

Was there an autopsy? Not

What test confirmed diagnosis? P.S. & Operation

(Signed) J. V. Szczerbicki, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Kisco St. Louis Cemetery	Aug 13 1923

20 UNDERTAKER Barnes & Wright 1364 Park Ave ADDRESS

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every [illegible] information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78251

CERTIFICATE OF DEATH.

90 D78251
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Hall.

(a) RESIDENCE No. 404 Bowin Alley, Near North Ave. — City. ST., WARD)
(Usual place of abode)
(If non-resident give city or town and State)
Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Alfred Hall (husband)

6 DATE OF BIRTH (month, day, and year): Aug 18, 1873.

7 AGE: Years 49 | Months 11 | Days 23. | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cook. 021
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS
10 NAME OF FATHER: Alfred Thompson
11 BIRTHPLACE OF FATHER (city or town) (State or country):
12 MAIDEN NAME OF MOTHER: Harriett Brick
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Records. JOHNS HOPKINS HOSPITAL

15 AUG 12 1923 . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 9 .1923. to Aug 10 .1923.
that I last saw her alive on Aug 10, .1923.
and that death occurred, on the date stated above, at 6.35 P. m.
The CAUSE OF DEATH* was as follows:
Hypertension
Obesity

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertension.
(duration) yrs. 8 mos. ? ds.

18 Where was disease contracted if not at place of death? ?
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy.
(Signed) Chas. W. Cunningham M. D.
8/11. 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hamden Hill Belair Md
DATE OF BURIAL: Aug 13 / 1923

20 UNDERTAKER: John C. Mitchell
ADDRESS: 920 W. Fayette

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should be made CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See Instructions on back of certificates.

78252

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78252

D78252

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 Chelsea Terrace WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Franklin Bradway Morris.

(a) RESIDENCE. NO. 701 Chelsea Terr WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 18-1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Wholesale Meats

(c) Name of employer Swift & Co

9 BIRTHPLACE (city or town) (State or country) Clayton Del

PARENTS

10 NAME OF FATHER John Howard Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lincoln Pa

12 MAIDEN NAME OF MOTHER Rebecca B Bradway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila Pa

14 Informant J Howard Morris
(Address) 2101 Chelsea Terrace

15 Filed AUG 13 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-12 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug-4 — 1923, to Aug 12 — 1923, that I last saw him alive on Aug-12 — 1923, and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Pleurisy with effusion
(Aspirated 8/9/23)

— (duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (secondary) Acute dilatation of heart
with pulmonary Edema yrs. mos. 6 hrs

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 8/9/23

Was there an autopsy? no

What test confirmed diagnosis? Clinical and Operative

(Signed) Harley Cole M. D.

8/2 1923 (Address) 2212 Vermont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wilmington Del	Aug 14 1923

20 UNDERTAKER Wm Hickman Sons ADDRESS Phila Pa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

KODAK S·A·F

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, *etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Tuberculosis

Spec.—1-10-21—M&T—1500 Blks.

D78253

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78253

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hospital for Women of Maryland

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sarah E. Lucas

(a) RESIDENCE No. 137 Court Street, Luray, Va ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ..... ds. How long in U. S., if of foreign birth? yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced ~~HUSBAND~~ WIFE of Mr. John D. Lucas

6 DATE OF BIRTH (month, day, and year) Nov. 7, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	79	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harve de Grace
(State or country)

PARENTS

10 NAME OF FATHER Mr. Reuben Thompson

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ohio

12 MAIDEN NAME OF MOTHER Susannah Jean

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Emma B. Lucas
(Address) 101 W. 39th St

15 Filed AUG 13 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1923, to Aug 12, 1923, that I last saw her alive on Aug. 12, 1923, and that death occurred, on the date stated above, at 2 40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of colon.
hepatic flexure

(duration) ..... yrs. 3 mos ..... ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of July 24th 1923

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) Thomas G. Tannenbaum M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem DATE OF BURIAL 8-14-23

UNDERTAKER Herwig & Perkins Sons ADDRESS McCulloh Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78254

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D78254

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 35-42 (St.) Roland Ave (WARD) 43

2-FULL NAME Emma J. Shaffer

(a) RESIDENCE NO. 35-42 (Usual place of abode) ST. Roland Ave WARD

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Shaffer

6 DATE OF BIRTH (month, day, and year): Aug 28 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Richard Huger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Huger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: E. L. Grass (Address) 35-42 Roland Ave

15 Filed AUG 13 1923 19 ... ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 10 1923

17 I HEREBY CERTIFY, That I attended deceased from January 1922 to August 9 1923, that I last saw her alive on August 9 1923, and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Valvular disease of the heart

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Asthma

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H. Morrison, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Aug 13 23
20 UNDERTAKER: CHENOWETH & SON,	ADDRESS
3617 CHESTNUT AVE.	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THE mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back

Spec—12-23-21—E.B.R.S.—400 Bks.

D78255

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

19 161-001

Registered No. D78255

1-PLACE OF DEATH

City of BALTIMORE: (No. 500 S. Gilmor St. St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elinor Anna Hoensch

(a) Residence No. 500 S. Gilmor Street St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug. 10, 1923

7-AGE,	If LESS than 1 day,
....yrs. ....mos. 2 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Paul Hoensch

11-BIRTHPLACE OF FATHER (city or town) (State or Country),

12-MAIDEN NAME OF MOTHER, Anna Schuman

13-BIRTHPLACE OF MOTHER (city or town) (State or Country),

14- (Informant) Paul Hoensch

(Address) 500 S. Gilmor St.

15- Filed AUG 13 1923 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 12, 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1923 to Aug 12, 1923

that I last saw her alive on ....., 19....,

and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Prematurity

.....

.....

.....(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Atelectasis

.....(Duration)....yrs....mos. 2 ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy?.....

What test confirmed diagnosis? Clinical

(Signed) Edw V Cooksad M. D.

8/13, 1923 (Address) 24 N. Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL,
Loudon Park	Aug 14, 1923
20-UNDERTAKER,	ADDRESS
Henry H Weitz 16	1516 W Lombard St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78256

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78256

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3018 Edmondson Ave ST. 16 WARD)

2-FULL NAME Dorothy Elizabeth Keelan

(a) RESIDENCE. No. 3018 Edmondson Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. 3 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-16-1906

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	17	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Thomas A. Keelan

11 BIRTHPLACE OF FATHER (city or town) Balto. Md
(State or country)

12 MAIDEN NAME OF MOTHER Katherine H. Leonard

13 BIRTHPLACE OF MOTHER (city or town) Balto —
(State or country)

14 Informant Vincent L. Keelan S.J.
(Address) Loyola College

15 Filed ..... 19 ROBERT R. KRAUTER, Registrar
AUG 13 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1923

17 I HEREBY CERTIFY, That I attended deceased from July 28 . 1923, to Aug 11th . 1923,
that I last saw her alive on Aug 11th . 1923,
and that death occurred, on the date stated above, at 8:25 P m.

The CAUSE OF DEATH* was as follows:

Parenchymatous Tuberculosis.

(duration) yrs. mos. 21 ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? inspection

(Signed) Geo. E. Wells, M. D.

. 19 (Address) 1521 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral.	8-14 1923
20 UNDERTAKER	ADDRESS
James Dignan & Son	1500 E Baltimore

R. R. WHITE LABEL, WHITE UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78257

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D78257

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1917 Fremont Ave ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter S. Hoddinott

(a) RESIDENCE NO. 1917 Fremont Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
48	about			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Maryland

PARENTS

10 NAME OF FATHER: Charles E. Hoddinott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary A. Fuchsburger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Chas. E. Hoddinott
(Address) 1917 Fremont Ave

15 Died AUG 13 1923 ROBERT R. KRAUTER Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1923

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1923, to Aug 11, 1923

that I last saw him alive on Aug 11, 1923,

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 1 yrs. mos

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? S & Symptoms

(Signed) Dr Thos F Kane, M. D.

, 19 (Address) Fremont Ave & Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Gen. London Park

DATE OF BURIAL: Aug 14 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E North

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Adreon

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78258

CERTIFICATE OF DEATH.

44 1 D78258

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3730 Old Frederick Road ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Ellen Adreon

(a) RESIDENCE NO. 3730 Old Frederick Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph L.

6 DATE OF BIRTH (month, day, and year) Jan 1, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	61	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Taylor.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sophia Donaldson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Geo Adreon

(Address) 3730 Old Frederick Road

15 Filed AUG 14 1923 ROBERT A. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1923

17

I HEREBY CERTIFY, That I attended deceased from July 28, 1923, to Aug 11, 1923, that I last saw her alive on Aug 11, 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Geo Adreon M. D.

8/12 1923 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	Aug 14 1923
20 UNDERTAKER	ADDRESS
H. M. Cook	502 E. Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78259

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D78259

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 1335 Carroll St. St. 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida Loosday

(Residence in Baltimore: No. 1335 Carroll St. St. 37 yrs. ..... mos. ..... ds.)

B—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female | 4-COLOR OR RACE: Colored | 5-Single, Married, Widowed, or Divorced, (Write the word.): Married

6-DATE OF BIRTH. ..... (Month) ..... (Day) 1855 (Year)

7-AGE. 68 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundress.
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country): Md.

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lillie D Williams

(Address) 1335 Carroll St

15- Filed AUG 13 1923 19.. ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 10 (Day) 23 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) ..... yrs. ..... mos. 24 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Claude Knabel M. D.
(Coroner)

Aug 30 1923 (Address) 1343 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn | DATE OF BURIAL: 8-13- 1923

20-UNDERTAKER: Daniel Easton | ADDRESS 716 Pa ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78260

CERTIFICATE OF DEATH.

X/46 D78260

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp ST. 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Norris

(a) RESIDENCE NO. Fallston Md. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr C. E. Norris

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: W Comer Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co Md

12 MAIDEN NAME OF MOTHER: Laura C Ringgold

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): C. E. Norris Fallston Md.

15 Filed AUG 13 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 12th 1923

17

I HEREBY CERTIFY, That I attended deceased from 8-8, 1923 to 8-12, 1923.

that I last saw h alive on 8-12, 1923,

and that death occurred, on the date stated above, at 9:45 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Puerpal infection

(duration) — yrs. — mos. 12 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Dr E. Hayward M. D.

8-12, 1923 (Address) Cathedral & Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Roselawn Md	Aug 14 23
20 UNDERTAKER: Wm J Tickner & Son	ADDRESS: North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78261

CERTIFICATE OF DEATH

90 D78261

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE: (NO. Agnes Home Calhoun and Lexington ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles A Holdsworthy

(a) RESIDENCE NO. Calhoun and Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna V. Holdsworthy

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Alex Holdsworthy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Retired

14 Informant Harriet A. Holdsworthy
(Address) 4001 Montgomery Ave.

15 Filed AUG 13 1923 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1923

17 I HEREBY CERTIFY, That I attended deceased from July 24 1923 to Aug 11 1923
that I last saw him alive on Aug 10 1923
and that death occurred, on the date stated above, at 9.30 A. m.
The CAUSE OF DEATH* was as follows:

Organic Disease Heart
(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Dilation Heart
(duration) yrs. mos. 18 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) James L. Harper, M. D.
8.12. 1923 (Address) 3 E 2 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cem. DATE OF BURIAL: Aug 13 1923

20 UNDERTAKER: John D. Mitchell ADDRESS: 1201 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78262

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001
161 D78262

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3700 E Lombard ST., No WARD)

2-FULL NAME Louis T. Rausch

(a) RESIDENCE NO. 3700 E Lombard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 11 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 800

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country) .....

PARENTS

10 NAME OF FATHER Wm T. Rausch

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) .....

12 MAIDEN NAME OF MOTHER Katherine Schaefer

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) .....

14 Informant Mrs T. Rausch
(Address) 3700 E Lombard

Aug 13 1923 F. A. M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug 13 1923

17 I HEREBY CERTIFY, That I attended deceased from August 11 19 23 to August 13 19 23
that I last saw him alive on August 12 19 23
and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

Premature Birth (duration) ..... yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Thrombosis Utero (duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Geo. W. Miller M. D.

B. 1923 (Address) 1031 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 13 1923
20 UNDERTAKER	**ADDRESS**
John Welliver	2308 Eden

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78263 HEALTH DEPARTMENT—CITY OF BALTIMORE D78263

CERTIFICATE OF DEATH.

3/2

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 E. Lanvale ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence E. Moore

(a) RESIDENCE NO. 1516 E Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 9 mos. 1 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 11 1902

7 AGE	Years	Months	Days	If LESS than 1 day,... hrs. or ....min.
	20	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER William H. Moore

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Rosa K. Hubert

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Mrs. William H. Moore

(Address) 1516 E Lanvale St

15 Date AUG 13 1923 F. A. K. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1922 to Aug 12th 1923.

that I last saw h[illegible] alive on 12th Aug 1923.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs,

1 year (duration) yr. 1 mos. ds.

CONTRIBUTORY (Secondary) Heart Exhaustion.

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms.

(Signed) [illegible] M. D.

19 (Address) S. W. Cor. Calvert & Preston Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL Aug. 16 1923

20 UNDERTAKER Henry Hoerth Son

ADDRESS 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78264

CERTIFICATE OF DEATH.

101-001

D78264

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1307 N Chapel ST., 8 WARD)

2-FULL NAME Edward Keys

(a) RESIDENCE NO. 1307 N. Chapel ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 23-23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Julius Keys

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Virginia Fowler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Annie Keys (Address) 1307 N. Chapel.

15 Filed, ... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1923, to Aug 12, 1923, that I last saw him alive on Aug 12, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia Lobar

(duration) yrs. mos 0 ds.

CONTRIBUTORY (Secondary) (b) Anemia

(duration) yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C. E. Flowers M. D. M. D.

(Address) 712 S. Bond St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Aug 13 19

20 UNDERTAKER Sam'l N. Chase & Sons

ADDRESS 1300 Mad

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78265

CERTIFICATE OF DEATH.

31 D78265

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Plantz

(a) Residence No. 1418 Light St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): 1845

7-AGE: 77 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Virginia

PARENTS:

10-NAME OF FATHER: Isaac Seavy

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Virginia

12-MAIDEN NAME OF MOTHER: America Davis

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Virginia

14-Informant: Municipal Hospital Records

(Address):

15-Filed AUG 13 1923 J. L. R. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): August 10, 1923

17- I HEREBY CERTIFY, That I attended deceased from August 5 19 23 to August 10 19 23

that I last saw her alive on August 10 19 23

and that death occurred, on the date stated above, at 7:05 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? X-ray & Lab

(Signed) Claude G. Drane M. D

8-11 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug. 13 1923
20-UNDERTAKER: George J. Smith	ADDRESS: 532 Hollins St

Filed EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. NAME should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78266

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 D78266

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 643 S. Monroe St. ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. Reed,

(a) RESIDENCE. NO. 643 S. Monroe St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White.	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Reed,

6 DATE OF BIRTH (month, day, and year) Mar 17, 1873.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder.

(b) General nature of industry, business, or establishment in which employed (or employer) Foundry.

(c) Name of employer 047

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER John Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Barbara Keller.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mollie Reed
(Address) 186 [illegible] st

15 Filed AUG 13 1923 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11. 1923.

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1923, to Aug. 11, 1923, that I last saw him alive on Aug. 11, 1923, and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Microscopic

8/13/23 (Signed) J. Chas. Lorton, M. D.

(Address) 888 N. Rowland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

St Peters — May 14 19

20 UNDERTAKER — ADDRESS 23

John Steele 1210 N Fremont

D78237

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X41 D78267

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out Xn. 18.)

2-FULL NAME James Hagan

(Residence in Baltimore: No. (Glen Arm, Md.) St.; yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, ~~Married~~, Widowed, or Divorced, (Write the word.)

6-DATE OF BIRTH, Oct 2 1916
(Month) (Day) (Year)

7-AGE, 6 yrs. 11 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School boy
(b) General nature of industry, business, or establishment in which employed (or employer). [illegible]

9-BIRTHPLACE, (State or Country). Balto Co

PARENTS.

10-NAME OF FATHER, James Hagan

11-BIRTHPLACE OF FATHER, (State or Country). Balto Co

12-MAIDEN NAME OF MOTHER, Anna Sharkey

13-BIRTHPLACE OF MOTHER, (State or Country). Balto Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Hagan

(Address) Glen Arm

15- AUG 13 1923 192 J. L. K. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 12 23
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, Autopsy or Inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septic Sore Throat
Left Foot, accident
(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Exhaustion
(Duration) yrs. mos. ds.

(Signed) C. E. Hall M. D.
(Coroner.)

Aug 13 1923 (Address) 143 N. Bway

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Glen Arm	Aug 13. 1923
20-UNDERTAKER E. L. Stiffler	ADDRESS 1249 North Ave

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78268

CERTIFICATE OF DEATH.

88 D78268

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Agnes Abernathy

(a) Residence No. 31 3d Ave Wagners Point Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew

6-DATE OF BIRTH (month, day and year) 1891

7-AGE. 32 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9-BIRTHPLACE (city or town) Balto. Md. (State or Country).

PARENTS.

10-NAME OF FATHER, John Thorne

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Catherine

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Hospital Records

(Address)

15- Filed ... 19.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 11-1923

17- I HEREBY CERTIFY, That I attended deceased from 8/10/23, 19.. to 8/11/23 19..

that I last saw her alive on 8/11/23 19..

and that death occurred, on the date stated above, at 3.20 P m.

The CAUSE OF DEATH* was as follows:

Subacute Bacterial Endocarditis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure 6 hrs.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. W. Holley M. D.

8/13, 1923 (Address) Mercy

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Cross MCE

DATE OF BURIAL, 8/14 19 23

20-UNDERTAKER. William Hawkins

ADDRESS 16 E Eastern

Should be carefully filled. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

D78269

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 1/12

D78269

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1027 N. Eden St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henrietta Brewer

(Residence in Baltimore: No. 1027 N. Eden St. 3 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widow(er), or Divorced, (write the word.)
Female	colored	married

6-DATE OF BIRTH. Jan. 20 1896
(Month) (Day) (Year)

7-AGE. 27 yrs. 6 mos. 14 ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: housework
(b) General nature of industry, business, or establishment in which employed (or employer): at home

9-BIRTHPLACE, (State or Country), N. C.

PARENTS.

10-NAME OF FATHER. Henry Wynn.

11-BIRTHPLACE OF FATHER, (State or Country), N. C.

12-MAIDEN NAME OF MOTHER. Watkinson

13-BIRTHPLACE OF MOTHER, (State or Country), N. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Brewer

(Address) 1027 N. Eden St.

15- Filed AUG 31 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 9 192 3
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or Inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Portality Acute Indigestion

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos. H. Carter M. D.
(Coroner.)

8/10/23 192 (Address) 556 Frank Ave

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Robeson Va. DATE OF BURIAL, Aug. 14 1923

20-UNDERTAKER, Chris. N. Johnson ADDRESS 1 N. Carolina St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D78270

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78270

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1128 Hanlingate ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond E Richardson

(a) RESIDENCE NO. 1128 Hanlingate ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 27 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business, or establishment in which employed (or employer) ooo

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Balto-

PARENTS

10 NAME OF FATHER Elmer Nicholson

11 BIRTHPLACE OF FATHER (city or town) Balto-
(State or country) Elmer Nicholson

12 MAIDEN NAME OF MOTHER Camilla Trulda

13 BIRTHPLACE OF MOTHER (city or town) Balto-
(State or country)

14 Informant Elmer Nicholson.
(Address) 1128 Hanlingate Ave

15 Filed AUG 13 1923 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1923

17 I HEREBY CERTIFY That I attended deceased from Aug 12 1923 to Aug 12 1923

that I last saw him alive on Aug 12 1923

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

(Duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Gastro Enteritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? None Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John G Schwerin M. D.

. 19 (Address) 1176 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Aug.	14 1923
20 UNDERTAKER	ADDRESS
Wm Cook	502 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78271 HEALTH DEPARTMENT—CITY OF BALTIMORE D78271

CERTIFICATE OF DEATH. 317

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1265 S. Luzerne Av. ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Luba

(a) RESIDENCE NO. 728 S. Luzerne Av. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov. 26/1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pipe Fitter Apprentice

(b) General nature of industry, business, or establishment in which employed (or employer) Sparrows Point

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Lawrence Luba

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Anna Kashinicz

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Anna Stachowski
(Address) 220 S. Luzerne Ave

15 Filed AUG 13 1923, 19 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1923, to Aug. 11, 1923, that I last saw him alive on Aug. 11, 1923, and that death occurred, on the date stated above, at 9:15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

1

about (duration) yrs. 18 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry B. Athey, M. D.

, 19 (Address) 2504 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Aug 14 1923
20 UNDERTAKER	ADDRESS
John H. Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78272

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D78272

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 S. Madeira ST.: 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wawszyn Piwinski

(a) RESIDENCE. No. 217 S. Madeira ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Piwinski

6 DATE OF BIRTH (month, day, and year) July 25-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65		19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cooper for B & O

(b) General nature of Industry, business, or establishment in which employed (or employer) 273

(c) Name of employer B & O R.R

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wawszyn Piwinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katherine Kantorski
(Address) 217 ROBERT H. KRAUTER,

15 Burial Permit Clerk.

AUG 31 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923 to Aug 13, 1923

that I last saw h.e alive on Aug 12, 1923.

and that death occurred, on the date stated above, at 6.40 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Dis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Clyde Burns, M. D.

Aug 13, 1923 (Address) 2017 E 32nd, Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross German Hill Road	Aug 16 1923

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78273

CERTIFICATE OF DEATH.

90 D78274

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 28 S. Calhoun ST. 19 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J Darby.

(a) RESIDENCE No. 28 S. Calhoun St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 30th 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39 yrs.	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Autor for 009

(b) General nature of industry, business, or establishment in which employed (or employer) Md Casualty Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Peter Darby.

11 BIRTHPLACE OF FATHER (city or town) Portland,
(State or country)

12 MAIDEN NAME OF MOTHER Emma O'Shamesberry

13 BIRTHPLACE OF MOTHER (city or town) Portland
(State or country)

14 Informant Mary R. Darby.
(Address) 28 S Calhoun St

15 Filed AUG 13 1923 ROBERT R. KRAUSER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 10 1923

17 I HEREBY CERTIFY, That I attended deceased from July 24th, 1923, to Aug. 10th, 1923, that I last saw him alive on Aug. 9th, 1923, and that death occurred, on the date stated above, at 12 00 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure — Organic Valvular disease.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. Alexander Novey M. D.

(Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peter's Cemetery	aug 14 1923
20 UNDERTAKER	ADDRESS
John A Moran	3000 E Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78274 — 24001 — D78274

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 571 N. Howard St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Mary Ward

(Residence in Baltimore: No. 571 N. Howard St.; yrs.....mos.....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

6-DATE OF BIRTH. Unknown ....., 1..... (Month) (Day) (Year)

7-AGE. about 70 yrs.....mos.....ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housework
(b) General nature of industry, business, or establishment in which employed (or employer)..... of Furnished room House

9-BIRTHPLACE, (State or Country). Unknown

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. A. Moran

(Address) 3000 E. Baltimore St.

15-

Filed. AUG 13 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug 7 23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acc Injury —

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. 1 mos. ds.

(Signed) G. C. Dladd M. D. (Coroner)

(Address) 1453 N. Bway Aug 13 25

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Trinity City — DATE OF BURIAL. Aug 13 1923

20-UNDERTAKER. John A. Moran — ADDRESS 3000 E. Baltimore

Spec.—1-10-21—M&T—1500 Bks.

D78275

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-00 D78275

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., 12 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna Tully

(a) RESIDENCE NO. 1302 W. 25th ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 50 yrs. ... mos. ... ds.

N. B.—WRITE CLEARLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas P. Tully

6 DATE OF BIRTH (month, day, and year): 1852

7 AGE — Years: 71 — Months: — Days: — If LESS than 1 day, ... hrs. or ... min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): 021

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John McCormick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Mrs. Jennie Thompson.

(Address): 130 W. 25th St.

15 Filed AUG 13 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): August 12 1923

17 I HEREBY CERTIFY, That I attended deceased from August 10, 1923, to August 12, 1923, that I last saw her alive on August 12, 1923, and that death occurred, on the date stated above, at 11.05 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation,
Cerebral thrombosis

Unknown. (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Hemiplegia (duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. H. T. Hundley, Jr. M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Aug 14 1923

20 UNDERTAKER: F. A. Krause & Son — ADDRESS: 703 Hanover

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78276

CERTIFICATE OF DEATH.

31 D78276

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 800 Belgian Ave ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank A Rehm

(a) RESIDENCE NO. 800 Belgian Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carola A. Rehm

6 DATE OF BIRTH (month, day, and year) April 14 96

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Automobile

(b) General nature of industry, business, or establishment in which employed (or employer) Mechanic

(c) Name of employer 031

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jos M J. Rehm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Fahey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Jos. M. J. Rehm
(Address) 800 Belgian Ave

15 Filed AUG 13 1923 ROBERT B. KRAUTER, Registrar
2239 York Rd
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1923

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1923, to Aug 10, 1923, that I last saw h[illegible] alive on Aug 10, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) ..... yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? U.S.F. - 1918

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. W. Wheaton, M. D.

, 19 (Address) 4239 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Govans	Aug. 14, 1923

20 UNDERTAKER J. C. Windsheld ADDRESS 914 Brehms Ln

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D78277

D78277

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 131 S. Register ST., V WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Lehman

(a) RESIDENCE NO. 131 S. Register ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Jonas

6 DATE OF BIRTH (month, day, and year) July 15, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	70		28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... at home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joshua Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Jones Lehman
(Address) 131 S. Register

15 Filed AUG 13 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb ..... 1923 to Feb 18 1923

that I last saw h[illegible] alive on Feb 1923

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Mitral Regurgitation
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cardiac decompensation
(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Fred. A. Rees, M. D.

, 19 (Address) 24 S. B'dway.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Aug 10 1923
20 UNDERTAKER Perkins & Jenkins	ADDRESS 739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D78278

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44

D78278

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital St., 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Hammer

(a) Residence No. 414 S. Chapel St., 2 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, (widowed) Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1862

7-AGE. 61 yrs. mos. ds.

If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 240

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore, Md

PARENTS.

10-NAME OF FATHER, John Hammer

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Municipal Hospital Records

(Address)

15- Filed ..... 192 .....

Registrar.

AUG 13 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 12 1923

17- I HEREBY CERTIFY, That I attended deceased from July 25 1923 to Aug 12 1923

that I last saw h. alive on Aug 12 1923

and that death occurred, on the date stated above, at. 7.25 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. 6 mos. (history) ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of ?

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude B. Drane M. D

8-12, 1923 (Address) Municipal Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
Mount Carmel Cem	Sept. 15 1923
20-UNDERTAKER.	**ADDRESS**
Lilly & Zeiler	4008 S. Wolfe St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78279

D78279

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 610 S. Rose ST., 1 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Milton Backert.

(a) RESIDENCE NO. 610 S. Rose ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 11 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 5th 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Andrew M. Backert.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Rose Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Andrew M. Backert.

(Address) 610 S. Rose St.

15 Filed AUG 19 1923, 19 Robert P. Harrison, Registrar

Asst. Deputy Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12th 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 11, 1923, to Aug 12, 1923,

that I last saw h- alive on Aug 12, 1923,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Collapse

for Recent Infection

(duration) yrs. mos 1/2 ds.

CONTRIBUTORY (Secondary) Gastritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

(Address) 1814 S. Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	Aug 14th 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	4033 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Catarrh of Intestines

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78280 D78280

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 817 N. Port St. ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob C. Soellner

(a) RESIDENCE. NO. 817 N. Port St ST., 7 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Soellner.

6 DATE OF BIRTH (month, day, and year) May. 18-1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	2	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone-Waxer

(b) General nature of industry, business, or establishment in which employed (or employer) 075

(c) Name of employer Hillgartner Co.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Frederick Soellner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna Strigel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Margaret Soellner
(Address) 817 N. Port St

15 Filed ..... 19 ..... Registrar

Robert P. Garrison
Asst. Records Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 10 1923

17 I HEREBY CERTIFY, That I attended deceased from July 27 1923 to Aug 10 1923, that I last saw him alive on Aug 9 1923, and that death occurred, on the date stated above, at 8.05 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? By Exam

(Signed) Jos C Glades, M. D.

(Address) 1430 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Aug. 14 1923
20 UNDERTAKER Lilly and Zeiler	ADDRESS 403 S. Wolfe St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78281

CERTIFICATE OF DEATH.

X118-607 D78281

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST., 9 WARD)

2-FULL NAME Joseph Griffith Jr

(a) RESIDENCE NO. Rockview Rd ST. WARD .....
(Usual place of abode) Stemmers Run (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	married

5a If married, widowed, or divorced (or) WIFE of Kate Griffith

6 DATE OF BIRTH (month, day, and year) Unk. 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brass Finisher

(b) General nature of industry, business, or establishment in which employed (or employer) 010

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Henry Jacob Jaeckel (Address) Solvay Place

15 AUG 13 1923 19 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1923 to Aug 11, 1923.

that I last saw him alive on Aug 11, 1923,

and that death occurred, on the date stated above, at 8 00 m.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug 1, 1923

Was there an autopsy? No

What test confirmed diagnosis? Operative findings

(Signed) Thos. Woodbridge Dickson M. D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL Aug. 16 1923

20 UNDERTAKER Tilly and Feile ADDRESS 403 S. Wolfe

UG 13 1923

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78282

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D78282

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Frederick Ave.nr Athol ST., Gate 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph H. Brummel

(a) RESIDENCE NO. Frederick Ave. nr Athol ST., Gate WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia O. Brummel

6 DATE OF BIRTH (month, day, and year) Oct. 4" 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Florist

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph H. Brummel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co. Md.

12 MAIDEN NAME OF MOTHER Mary Ann Flickinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanover Md.

14 Informant Amelia O. Brummel (Address)

15 Filed AUG 31 1923, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11" 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 4. 1923 to Aug 11 1923.

that I last saw him alive on Aug 11 1923

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Nephritis (duration) yrs. mos 16 ds

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home of Death

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? yes

(Signed) asa I Wessels, M. D.

8/11 1923 (Address) 2565 Frederick Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug. 13" 1923
20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W. Balto St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78283

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78283

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hospital for Women of Md ST., 8 WARD)

2-FULL NAME Estella Florence Savage

(a) RESIDENCE NO. 2117 E. North ave ST., 8 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Josp. U. Savage

6 DATE OF BIRTH (month, day, and year): April 23, 1869

7 AGE: 54 Years 3 Months 19 Days. If LESS than 1 day, 0 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Jno. Lyons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Margaret Seymour

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Joseph U. Savage
(Address) Baltimore, Md

15 ..... 19 ..... Registrar

AUG 13 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from July 3 1923 to Aug 12 1923.
that I last saw her alive on Aug 12 1923.
and that death occurred, on the date stated above, at 12:45 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Common duct stones

Operation (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? 2117 E. North ave.

Did an operation precede death? Yes Date of July 14, 1923

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) Norman E. Cummerbatch M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Aug 15 1923

20 UNDERTAKER: Robt. T. Turner Inc — ADDRESS: 1440 N. Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78284

CERTIFICATE OF DEATH.

57

D78284

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Bartholomaei

(a) RESIDENCE No. 1830 Walbrook Ave. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~and WIFE~~ of Charlotte Bartholomaei

6 DATE OF BIRTH (month, day, and year) — 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER Christian Bartholomaei

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna Shane

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany.

14 Informant University Hosp. records. (Address)

15 Filed AUG 31 1923, 19 ..... Registrar

C 131923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1923

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1923, to Aug 12, 1923, that I last saw h living alive on Aug 12, 1923, and that death occurred, on the date stated above, at 1000 Am.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) Unknown mos. ..... ds.

CONTRIBUTORY (Secondary)

Diabetic Coma. (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? — Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory Findings.

(Signed) John M. Edmonds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Harry H. Waldon Pk	Aug 15 1923
20 UNDERTAKER	**ADDRESS**
Harry H. Witzke	153 W. Lanvale

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78285

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78285

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of BALTIMORE: (No. Race St., 23 Ward) Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Burke H Little

(Residence in Baltimore: No. Manteo Virginia St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
M	W	S

6-DATE OF BIRTH. Unknown (Month) (Day) (Year)

7-AGE. 21 yrs. — mos. — ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work U.S Marine
(b) General nature of industry, business, or establishment in which employed (or employer) 086

9-BIRTHPLACE, (State or Country). Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country) Unknown

12-MAIDEN NAME OF MOTHER, Mrs Julia alias Little

13-BIRTHPLACE OF MOTHER, (State or Country): ?

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 Eutaw st

15-

Filed AUG 13 1923 192.. Robt. P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Aug 10 23 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or Inquiry) find that said deceased came to Drowning death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) C. C. Jacobs M. D.

(Coroner.)

(Address) 145 N Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
MABSCA t C.W.V. 8/13 1923

20-UNDERTAKER. ADDRESS
Jack Lewis 1439 Eutaw st

—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

KODAK S·A

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78286

CERTIFICATE OF DEATH.

90 D78286

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 727 N. Collington Ave. ST.; 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Childs

(a) RESIDENCE, No. 727 N. Collington Ave ST.; 7 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 9 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mercia A. Childs

6 DATE OF BIRTH (month, day, and year) Oct. 28, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Jackria Childs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Maryland

12 MAIDEN NAME OF MOTHER Mary Pantyfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Maryland

14 Informant Charles M. Childs
(Address) 17 S. Summerset

15 Filed . 19 Robert P. Harrison Registrar

UG 131923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-10 1923

17 I HEREBY CERTIFY, That I attended deceased from 8-8 . 1923, to 8-10 . 1923 that I last saw him alive on 8-9 . 1923 and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

Signed 8-11 . 1923 (Address) F. Fred Lanzke, M. D. 700 N. Bath St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	Aug 14 1923
20 UNDERTAKER	ADDRESS
William G. Schaeffer	1816 Mount

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78287

CERTIFICATE OF DEATH.

15 D78287

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Home for Incurables Guilford Ave. & 21at. ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Schoolfield

(a) RESIDENCE NO. Guilford Ave. & 21st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) ----------

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
84	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Luther A. Schoolfield

11 BIRTHPLACE OF FATHER (city or town) (State or country): Prince Anne, Maryland

12 MAIDEN NAME OF MOTHER: Hannah D. Dickehut

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant: Miss Eleanor M. Duval

(Address): 1824 St. Paul St.

15 Filed ....., 19..... Registrar

G 1 81923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 5th, 1923, to Aug 12th, 1923, that I last saw h[illegible] alive on Aug 11th, 1923, and that death occurred, on the date stated above, at 12 [illegible] m.

The CAUSE OF DEATH* was as follows:

Septicaemia from Gangrene of Foot.

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Senility Arterio-sclerosis.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Signs & symptoms

(Signed) J. A. Ashland, M. D.

Aug 13 1923 (Address) 40 W. Biddle st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery

DATE OF BURIAL: 8/14 1923

20 UNDERTAKER: Henry W. Mears & Son

ADDRESS: 805 N. Calvert

REMARK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

D78288

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78288

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Esplanade 813 (Street) WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bettie S. Fuechsl

(a) RESIDENCE No. Esplanade 813 (Street) WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 31 1863

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
59	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Importers'-Ladies

(b) General nature of industry, business, or establishment in which employed (or employer): Wearing

(c) Name of employer: Apparel 045

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Levy Schiff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Henrietta Goldman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Frankel

(Address): Esplanade Apt.

15 Filed UG 31923 . 19 Registrar

Robert P. Harrison, Vital Records Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1, 1922, to Aug. 12, 1923, that I last saw h[illegible] alive on Aug. 11, 1923, and that death occurred, on the date stated above, at 4 30 A.m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis of abdominal viscera, myocarditis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus

(duration) about yrs. mos. 1½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan. 1, 1923

Was there an autopsy? No

What test confirmed diagnosis? Pathological exam. ? pneumonia

(Signed) Theo. H. Morrison, M. D.

19 (Address) 1013 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ohel Shalom Cem

DATE OF BURIAL: 8/14/1923

20 UNDERTAKER: David Sandkerson

ADDRESS: 118-20 W Mt. Royal Ave

mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that TION is very important. See instructions

Spec.—1-10-21—M&T—1500 Blks.

165384
D78289

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78289

16-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. [illegible] WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thurn Wallace.

(a) RESIDENCE No. 1104 Mc Culloch St. ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced
~~HUSBAND of~~
~~(or) WIFE of~~ ~~Edith Wallace~~ Mother.

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years — Months 7 — Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child.
(b) General nature of industry, business, or establishment in which employed (or employer): 000
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS
10 NAME OF FATHER: John Wallace
11 BIRTHPLACE OF FATHER (city or town) (State or country):
12 MAIDEN NAME OF MOTHER: Edith.
13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

15 [illegible] 1923 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1923, to Aug 6, 1923.
that I last saw him alive on Aug 6, 1923,
and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:
Bacillary Dysentery
(Flexner)

(duration) yrs. mos 10+ ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Bacteriological

(Signed) Horton Casparis M. D.
, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL
DATE OF BURIAL: Aug 11 1923

20 UNDERTAKER
ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D78290

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78290

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeths Home ST.; 9 WARD) REGISTERED NO. C 7

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip Malone

(Residence in Baltimore: No. St. Elizabeth's Home St.; yrs., mos. ds.)

Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (*Write* the word.)
male	negro	

6-DATE OF BIRTH March 23, 1920 (Month) (Day) (Year)

7-AGE, 3 yrs. 4 mos. 18 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: 000
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Cumberland, Md

PARENTS.

10-NAME OF FATHER, Ralph Malone

11-BIRTHPLACE OF FATHER (State or Country), Cumberland Md

12-MAIDEN NAME OF MOTHER Ruth Malone

13-BIRTHPLACE OF MOTHER (State or Country), Cumberland Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15- Filed ....., 191.... Registrar.

AUG 131923

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 10 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 25 1923, to August 9 1923, that I saw h— alive on August 9 1923, and that death occurred, on the date stated above, at 3A. m.

The CAUSE OF DEATH* was as follows:

Measles

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Frank J. Ayd M. D.

Aug 10/23 191... (Address) 2005 E. Monument St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL, ..., 191...

JOHNS HOPKINS HOSPITAL

20-UNDERTAKER ADDRESS

Comptroller's Office

Spec—12-23-21—E.B.R.S.—400 Bks.

D78291

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78291

CERTIFICATE OF DEATH.

118-00

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Alfred Dobey

(a) Residence No... 1619 Druid Hill Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Live yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1898

7-AGE, 25 yrs. mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... 040

(b) General nature of Industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer.....

9-BIRTHPLACE (city or town)... W. Africa
(State or Country),

PARENTS.

10-NAME OF FATHER, Kongens Dobey

11-BIRTHPLACE OF FATHER (city or town). W. Africa
(State or Country),

12-MAIDEN NAME OF MOTHER, Titi ?

13-BIRTHPLACE OF MOTHER (city or town) W. Africa
(State or Country),

14- (Informant)... Hospital Records

(Address).....

15- [illegible] 192.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/11/23

17- I HEREBY CERTIFY, That I attended deceased from 8/9/23, 19.. to 8/11/23, 19..

that I last saw h~~im~~alive on 8/11/23, 19..

and that death occurred, on the date stated above, at 10.15-a m.

The CAUSE OF DEATH* was as follows:

Bilateral Inguinal Hernia

(Duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Surgical Shock 30 min

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 8/11/23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N. W. Dolley M. D.

, 19 (Address) Mercy.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, | DATE OF BURIAL, ... 19....

20-UNDERTAKER. | ADDRESS

AUG 31 1923

UNIVERSITY OF MARYLAND

JAMES F. GARRISON, CLERK.

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78292

CERTIFICATE OF DEATH.

D78292

1-PLACE OF DEATH Nursery and Childs Hospital

CITY OF BALTIMORE: (No. Frankfurt & Schroeder ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adelia Blessing Conklin

(a) RESIDENCE NO. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 14 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Great Bend (State or country) Pa.

PARENTS

10 NAME OF FATHER Henry Conklin

11 BIRTHPLACE OF FATHER (city or town) Great Bend (State or country) Pa.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 Filed ..... 1923 . 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 10 . 1923 . to Aug 12 . 1923 . that I last saw her alive on Aug 12 . 1923 . and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery (Flexner

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Nos Date of

Was there an autopsy? No

What test confirmed diagnosis? Stool culture

(Signed) Johnston Baldwin, M. D.

. 19 (Address) 1014 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health,

AUG 13 1923

WOODALL

Robert P. Harrison,

Bureau Records

STATE

THIS IS A PERMANENT RECORD. Every statement should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S signature to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

No 44023

Spec—12-23-21—E.B.R.S.—400 Bks.

D78293

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78293

CERTIFICATE OF DEATH.

15 129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal Hospital. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hall

(a) Residence No. 1439 Parish Alley St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Black	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6-DATE OF BIRTH (month, day and year) 1874

7-AGE. 49 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or .... min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer: .....

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Howey Hall

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Municipal Hospital Records

(Address) UNIV

15- Filed ..... 192 .....

Registrar.

AUG 7 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) August 7, 1923

17- I HEREBY CERTIFY, That I attended deceased from August 7 19 23 to August 7 19 23

that I last saw him alive on August 7 19 23

and that death occurred, on the date stated above, at 10:00 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) ..... yrs. ..... mos. ? ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Claude G. Dunn M. D

8-8-, 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND DATE OF BURIAL ..... 19 ....

20-UNDERTAKER, ... ADDRESS .....

AUG 13 1923

Robert P. Harrison, Commissioner of Health

Deputy Registrar

0820

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78294

CERTIFICATE OF DEATH.

90 D78294

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Hospital. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Prokoff

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 140

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records.
(Address)

15 Filed AUG 13 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 9 1923

17

I HEREBY CERTIFY, That I attended deceased from November 19 1922 to August 9 1923.

that I last saw him alive on August 8 1923,

and that death occurred, on the date stated above, at 5:45 A.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Chronic Myocarditis (Degenerative)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude G. Drane, M. D.

8-11 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER Commissioner Health.	ADDRESS

N.B. WRITE PLAINLY, WITH PEN AND INK—NOT PENCIL, WITH ONE ENDING INK—mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

UNIVERSITY OF MARYLAND

AUG 13 1923

Mary P. Merriam, Clerk

Spec.—1-10-21—M&T—1500 Bks.

D78295

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78295

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland General Hosp. St., 11 Ward)

2-FULL NAME Mrs. Millie Spencer

(a) RESIDENCE No. Lapidum, Maryland St.

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND~~ of WIFE of C. M. Spencer

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 70				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Lapidum Md

PARENTS

10 NAME OF FATHER: Joseph Donahoo

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Scarboro

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Dublin Md

14 Informant: A. B. Bailey

(Address): Darlington Md

15 Filed ..... 19 .....

Registrar

JG 131923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 13 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 7, 1923, to Aug 13, 1923, that I last saw her alive on Aug. 13, 1923, and that death occurred, on the date stated above, at 12:05 P m.

The CAUSE OF DEATH* was as follows:

Cardio-vascular Hypertension.

(duration) yr. mos ds.

CONTRIBUTORY (Secondary): Acute Dilatation of Heart. 10 minutes

(duration) yrs. mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Walter H. Shealy, M. D.

19 (Address) Md. General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Darlington Md.

DATE OF BURIAL: 8-13 1923

20 UNDERTAKER: E. F. Bladen

ADDRESS: 6 West St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

165638.

D78296

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78296

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Gilmore. New Orleans, La.

(a) RESIDENCE No. 3008 St. Charles Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ Wm V. Gilmore Brother.

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE: Years 66 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Thomas.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Clohecy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N Y

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL

15 Filed . 19 Registrar

UG 131923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 9 . 1923 . to Aug 12 . 1923 .

that I last saw her alive on Aug 12 . 1923 .

and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood sugar etc.

(Signed) Trevor Owen, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Orleans La — DATE OF BURIAL: Aug 13 1923

20 UNDERTAKER: John O Mitchell — ADDRESS: 1201 W Fayette

IMPORTANT—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D78297 HEALTH DEPARTMENT—CITY OF BALTIMORE D78297

CERTIFICATE OF DEATH.

Registered No. 38

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Lydus

(a) Residence No. Bya View Hospital. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1895

7-AGE. 27 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer). 043

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Greece

PARENTS.

10-NAME OF FATHER, Harry Lydus

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Greece

12-MAIDEN NAME OF MOTHER, Mary ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Greece

14- (Informant) Municipal Hospital Records

(Address)

15- Filed 1923 Registrar.

UG 131923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) August 10, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 6, 1923 to August 10, 1923.

that I last saw him alive on August 9, 1923,

and that death occurred, on the date stated above, at 3:45 A.M.

The CAUSE OF DEATH* was as follows:

Syphilis
C. N. S. Syphilis (General Paresis)

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Claude C. Heard M. D.

8-14-23 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
WOODLAWN CEM	8/14 1923

20-UNDERTAKER,	ADDRESS
ROBERT BROOKS & SON	CALHOUN HOLLINS ST

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78298

CERTIFICATE OF DEATH.

90 D78298

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2121 St Paul St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeremiah Wood

(a) RESIDENCE No. 2121 St Paul St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~ Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Matilda Wood

6 DATE OF BIRTH (month, day, and year) ? ?

7 AGE: Years about 83 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 1920

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Charles H. Meyers

(Address): 1744 E. North Ave

15 Filed AUG 13 1923, 19 ..... Robert F. ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1923

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1923, to Aug 13th, 1923, that I last saw him alive on Aug 12th, 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Valvular Disease of Heart

(duration) yrs. 4 mos. 27 ds.

18 Where was disease contracted if not at place of death? 2121 St Paul St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Frank R Lynch, M. D.

Aug 13, 1923 (Address) 322 N Greene

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: U. S National — DATE OF BURIAL: Aug 15 1923

20 UNDERTAKER: William Cook — ADDRESS: 502 E North Ave

AUG 13 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78299

CERTIFICATE OF DEATH.

D78299

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 211 Paladse ave ST. WARD)

2-FULL NAME Agnes Skipper

(a) RESIDENCE NO. 211 Paladse ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND of or) WIFE of: Eli Skipper

6 DATE OF BIRTH (month, day, and year): Nov 14 1861

7 AGE: Years 62; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Wm Constantine

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Wirth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Eli Skipper

(Address): 24 Paladse St

15 Filed AUG 13 1923, 19 . Roberta P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 12 1923

17 I HEREBY CERTIFY, That I attended deceased from June 6. 1920. to Aug 11 . 1923.

that I last saw her alive on Aug 11 . 1923

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) 3 yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Mar. 22-23

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Samuel Kahn Brack, M. D.

Aug 13 1923 (Address) 1412 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Aug. — DATE OF BURIAL: 15 — 1923

20 UNDERTAKER: Wm Cook ADDRESS: 502 E Balto

Deputy Clerk.

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should file CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

16546. D78300

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 D78300

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillie Austin.

(a) RESIDENCE NO. 2418 E. Chase St. City ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) Wife of~~ Wesley Austin (Husband).

6 DATE OF BIRTH (month, day, and year) April 27, 1883.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40	3	16.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of Industry, business, or establishment in which employed (or employer) 027

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Stewart Webster.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Alphonsa Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Record

(Address)

15 Aug 2, 1923 Registrar

C 131923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1923, to Aug 13, 1923, that I last saw her alive on Aug 13, 1923, and that death occurred, on the date stated above, at 5.20 A. m.

The CAUSE OF DEATH* was as follows:

Adenocarcinoma of Pelvis Uteri

(duration) yrs. 16 mos. 21 ds.

CONTRIBUTORY (Secondary) Streptococcus Peritonitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 6

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Ruth Lundell M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Veals Island Md. DATE OF BURIAL: Aug 14 1923

20 UNDERTAKER: Wm Cook ADDRESS: 502 East North ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

078301

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X16-002

078301

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 14 WARD)

2-FULL NAME Irvin Gill

(a) RESIDENCE NO. Cockeysville, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 19, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Harry E. Gill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sara F. Raver

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harry E. Gill

(Address) Cockeysville Md

15 Filed AUG 14 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1923, to Aug 11, 1923, that I last saw him alive on Aug 11, 1923, and that death occurred, on the date stated above, at 9:15 A. m.

The CAUSE OF DEATH* was as follows:

Bacillary dysentary

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) P B Price, M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Aug 14 1923
20 UNDERTAKER J. F. Edmiston	ADDRESS Reisterstown Md

NOTE—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78302

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D78302

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 220 Essex ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Berger

(a) RESIDENCE NO. 220 Essex ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaretha Berger

6 DATE OF BIRTH (month, day, and year) March 19 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) 013

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Margaretha Berger (Address) 22 Von Essex Pl

15 Filed AUG 14 1923, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 11 1923

17 I HEREBY CERTIFY, That I attended deceased from 6 Aug, 1923, to 11 Aug, 1923, that I last saw h alive on 10 Aug, 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Liver

Patient had been under the Care of Dr Berger

(Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 5/9/23

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? Blood + Urine

(Signed) [illegible] M. D.

, 19 (Address) 301 Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emanuel Cemetery	Aug 14, 1923
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Fleet St.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78303 — 49 D78303

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Howard A. Kelly Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. 1418 Eutaw Pl. ST., 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward S. Posey Jr.

(a) RESIDENCE NO. 16 S. Highland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 21- 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or min.
	15	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy.

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Edward S. Posey

11 BIRTHPLACE OF FATHER (city or town) (State or country) St. Mary's Co. Md.

12 MAIDEN NAME OF MOTHER Hilda Herman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Edward S. Posey Jr.
(Address) 16 S. Highland Ave

15 Filed AUG 14 1923, 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1923. to Aug. 11, 1923
that I last saw him alive on Aug 11, 1923
and that death occurred, on the date stated above, at 8:25 A. m.

The CAUSE OF DEATH* was as follows:

Lympho-sarcoma

(duration) yrs. 2 mos da.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of July 9 '23

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological diagnosis Gland removed

(Signed) H. Edward M. D.

, 19 (Address) 1418 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: Aug 14 1923

20 UNDERTAKER: H. Sander & Sons — ADDRESS: 1710 Fleet St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78304

CERTIFICATE OF DEATH.

31 D78304

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2461 Buchanan ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Goldie Roberts

(a) RESIDENCE. NO. 2461 Buchanan WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or WIFE of): Reginald Roberts

6 DATE OF BIRTH (month, day, and year): Sept 12-1898

7 AGE — Years: 24 — Months: 11 — Days: — — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer: Herself.

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Wm H. Gittings

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co Md.

12 MAIDEN NAME OF MOTHER: Rachael Talbot

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md

14 Informant: Clarence Gittings (Address) 407 E. 24th St

15 Filed AUG 14 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 12 1923

17 I HEREBY CERTIFY, That I attended deceased from 2-7 1923, to 12 Aug. 1923 that I last saw h alive on 11 " 1923 and that death occurred, on the date stated above, at 12.15 p.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) — yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Patient

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Mayfield Dehoff, M. D.

(Address) 421 N. Carey St. 12/8/23

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: Aug 14 1923

20 UNDERTAKER: Samuel Hawsley — ADDRESS: Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Positive Sputum
for Tuberculosis

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78305

CERTIFICATE OF DEATH.

118-002 D78305

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen. Hospt. ST., 15 WARD)

2-FULL NAME Mrs Margaret E. Milbourne

(a) RESIDENCE NO. 4005 Hawthorne Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 11 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

THIS DEPARTMENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of L.Jeff Milbourne

6 DATE OF BIRTH (month, day, and year) AUG.20 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min.
	72	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER William McGee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah A.Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant L.Jeff Milbourne (Address) 4005 Hawthorne Aye.

15 Filed AUG 14 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8.12.23

17 I HEREBY CERTIFY, That I attended deceased from 8.9.23, 19 , to 8.12.23, 19 ,

that I last saw h alive on 8.12.23, 19 ,

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Trauma

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of 8-10-23

Was there an autopsy? No

What test confirmed diagnosis? Operation & Clynical Signs

(Signed) Jno. A. Wyeth, M. D.

, 19 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Aug 15 1923
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78306

CERTIFICATE OF DEATH.

66 D78306

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 808 E. Pratt ST., 3 WARD)

2-FULL NAME John Sahmidt

(a) RESIDENCE NO 808 E. Pratt ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Mal	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About 60	—	—		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer —

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Police Dept
(Address) Eastern Dist

15 Filed AUG 14 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 11 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, and find that said deceased came to his death on the day stated above. (autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

..... (duration) ..... yrs. ..... mos. ..... ds. at once

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B. Horton M. D.
(Coroner.)

Aug 14th 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Aug 15 1923
20 UNDERTAKER George J. Ruth	ADDRESS 1705 Hayford Ave.

MARKING should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

165610 D78307

HEALTH DEPARTMENT—CITY OF BALTIMORE D78307

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Howard Baker.

(a) RESIDENCE No. 3124 E. Monument St. St., City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Baker (Father).

6 DATE OF BIRTH (month, day, and year) Jan. 26, 1923.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
—	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. (Old)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland,

PARENTS

10 NAME OF FATHER William Baker.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Viola Hartlove

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records. (Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 14 1923 ROBERT R. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13, 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1923, to Aug 13, 1923, that I last saw him alive on Aug 13, 1923, and that death occurred, on the date stated above, at 10:00 A. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not Dysentery)

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary) X (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Mt. Wilson Sanatorium?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X

(Signed) A. A. Weech, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn. DATE OF BURIAL Aug 14th 1923

20 UNDERTAKER Leo G. Cook ADDRESS North & Mary

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78308

CERTIFICATE OF DEATH.

74-001 D78308

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 W. Saratoga St. WARD 14)

2-FULL NAME Mrs E. Robinson

(a) RESIDENCE NO. 532 W Saratoga St. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 20-1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58		20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Plumber
(b) General nature of industry, business, or establishment in which employed (or employer) 054
(c) Name of employer Wm

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER David Robinson

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER Grace Thorn

13 BIRTHPLACE OF MOTHER (city or town) Balto Co Md
(State or country)

14 Informant David Robinson
(Address) 320 Belvidere Ave

15 Filed AUG 14 1923, 192 ROBERT R. KRAUTER, Burial Permit Clerk (Registrar)

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 12 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

..... (duration) ..... yrs. four mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) H H Leach, M. D. (Coroner.)

8-14, 1923 (Address) 320 Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem — DATE OF BURIAL Aug 17 1923

20 UNDERTAKER W. M. Routson — ADDRESS 230 N Eutaw St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78309

CERTIFICATE OF DEATH.

118-007 D78309

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 St Agnes Hosp ST.) WARD)

2-FULL NAME Mrs Agnes Morris

(a) RESIDENCE No. 2625 Maryland Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James Morris (deceased)

6 DATE OF BIRTH (month, day, and year) - - 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	58 yrs.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Chas Moriarity

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary McCarty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Jos Morris
(Address) 2625 Md Ave

15 Filed AUG 14 1923, 19.. ROBERT R. KRAUER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from August 14, 1923, to August 14, 1923, that I last saw her alive on August 14, 1923, and that death occurred, on the date stated above, at 2.15 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) ..... yrs. mos 6 ds.

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Edward A. Kalousha, M. D.

, 19 Address St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 8/17 1923

20 UNDERTAKER Wm J Baker & Sons

ADDRESS 13 N Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78310

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D78310

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 N. Caroline St ST., 8 WARD)

2-FULL NAME Mary Clarke Shaw

(a) RESIDENCE NO. 1617 N. Caroline St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gilles J. Shaw

6 DATE OF BIRTH (month, day, and year) June 29th, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Clarke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Alice Shaw

(Address) 1617 N. Caroline St

15 AUG 14 1923 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 13th 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 13, 1923, to Aug 13, 1923, that I last saw her alive on Aug 13, 1923, and that death occurred, on the date stated above, at 12.55 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Murmur & Exhaustion

(duration) Years yrs. mos ds.

CONTRIBUTORY (Secondary) Mitral Murmur

(duration) Years yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. D. Carman M. D.

Aug 14, 1923 (Address) 1701 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	8/17/23 19
20 UNDERTAKER	ADDRESS
Chas. F. Evans & Son	118 W. Mt. Royal Av

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78311

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78311

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1931 W. Lombard St

CITY OF BALTIMORE: (No. ..... ST., 16 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Sadofsky

(a) RESIDENCE NO. 1931 W. Lombard ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Anna Sadofsky

6 DATE OF BIRTH (month, day, and year) March 11, 1861

7 AGE: 62 (Years / Months / Days / If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer) Jones Land Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Sadofsky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Anna L. Sadofsky

(Address) 1931 W. Lombard St

15 Filed AUG 14 1923, 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 13th, 1923, to Aug 14th, 1923, that I last saw him alive on Aug 10th, 1923, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Xray and Clinical History

(Signed) L. L. Gordy, M. D.

3-14, 1923 (Address) 4218 Holyoke Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Aug 16 1923

20 UNDERTAKER: Wm. Cook Sons & Co. — ADDRESS: Howard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78312

CERTIFICATE OF DEATH.

1400 D78312

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Little Sisters of the Poor, 1074 Ward)

(If death occurred in a hospital or institution, give its NAME, instead of street and number.)

2-FULL NAME Mary O'Brien

(a) Residence No. Preston & Calvert St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, ~~Married,~~ ~~Widowed,~~ or ~~Divorced,~~ (Write the word.)
Female	White	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year) 1844

7-AGE. ~~79~~ yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work ood

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS

10-NAME OF FATHER. Patrick O'Brien

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Frances Finck

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) Sister Superior

(Address) Preston & Calvert

15- Filed. 192 Robert P. Harrison, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 13/23

17- I HEREBY CERTIFY, That I attended deceased from No record 19 to 19

that I last saw h.. alive on Aug 9 1923

and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemiplegia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Aug 13, 1923 (Signed) T. A. Dorsey, M. D. (Address) 1133 Valley St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
St Mary's Frantstown	Aug 16, 1923
20-UNDERTAKER. William Cook	ADDRESS 502 E North Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78313

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78313

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1944 Hebert ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Weber

(a) RESIDENCE NO. 1944 Hebert ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7-21.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	2	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John W. Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Sneziv

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) John W. Weber 1944 Hebert St

15 Filed , 19 Registrar

G 14 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-13 1923

17 I HEREBY CERTIFY, That I attended deceased from 8-12 , 1923, to 8-13 , 1923, that I last saw him alive on 8-13 , 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Toxemia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Convulsions.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T. H. C. Nelson M. D.

8/14/23 Address) 2757 W. Fredrick

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Aug 15th 1923
20 UNDERTAKER Wellauer Cook	ADDRESS 502 E Hoff

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Gastro Enteritis

Spec. 6-9-19—H. P. Co.—1000 Bks.

D78314

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78314

1-PLACE OF DEATH U. of Va. Hospital

CITY OF BALTIMORE: (No. 416, N. Jennings ST.: 4 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Murney.

(a) RESIDENCE. NO..... Suffolk Va ST., ... WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. 2 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4. COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 3" 1854

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
79	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER William Nurney

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Miss Hobbs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Mrs. L. H. Hobbs

(Address) 220 E. Pinner St. Suffolk Va.

15 Filed ..... , 19 .....

Registrar

AUG 14 1923

Robert P. Garrison, Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-13, 1923

17 I HEREBY CERTIFY, That I attended deceased from 8-12, 1923, to 8-13, 1923, that I last saw her alive on 8-13- , 1923, and that death occurred, on the date stated above, at 10.55 m.

The CAUSE OF DEATH* was as follows: Pneumonia

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death? S. S. State of Va.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical observation

(Signed) Geo. E. Wells, M. D.

, 19 (Address) 521 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Suffolk Va	Aug 14 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are required to report CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Broncho

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78315

CERTIFICATE OF DEATH.

90 D78315

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 453 Ilchester Ave St. 12 WARD)

2-FULL NAME Margaret Cloman Weber

(a) RESIDENCE No. 453 Ilchester Ave St., WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~ or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed~~, or ~~divorced~~
~~HUSBAND~~ of
(or) WIFE of H. A Weber.

6 DATE OF BIRTH (month, day, and year) 1856-9-9

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	3	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lady
(b) General nature of industry, business, or establishment in which employed (or employer) At Home
(c) Name of employer

9 BIRTHPLACE (city or town) Birkenhead
(State or country) England

PARENTS

10 NAME OF FATHER Christopher Cloman
11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland
12 MAIDEN NAME OF MOTHER dont Know
13 BIRTHPLACE OF MOTHER (city or town)
(State or country) dont Know

14 Informant Mr. J. H. Weber
(Address) 453 Ilchester Ave

15 Filed ....., 19 ..... Registrar

UG 14 1923 Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 13 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923, to Aug 13, 1923,
that I last saw her alive on Aug 13, 1923,
and that death occurred, on the date stated above, at 6 P m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas R. Goldsborough, M. D.

, 19 (Address) 2735 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Charlotte N. C.	8-14 1923
20 UNDERTAKER H. W. Perkins & Sons Co	ADDRESS Tidball Orchard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN shall indicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-615 / D78316 — 90 D78316

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 12 WARD)

2-FULL NAME Daniel O'Reardon

(a) RESIDENCE NO. Tudor Hall. University Parkway ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male. 4 COLOR OR RACE: White. 5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~

6 DATE OF BIRTH (month, day, and year) Dec. 7, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Steward

(b) General nature of Industry, business, or establishment in which employed (or employer): Hosp

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Daniel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Record (Address):

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 8th, 1923, to Aug 14, 1923, that I last saw him alive on Aug 14, 1923, and that death occurred, on the date stated above, at 2.25 a. m.

The CAUSE OF DEATH* was as follows:

Mesenteric Thrombosis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Myocarditis - Myocardial insufficiency

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 9-1923.

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Trevor Owen M. D.

Aug 14 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary Cem Annapolis — DATE OF BURIAL: 8-16 1923

20 UNDERTAKER: Henry W Fruitin Sons Co — ADDRESS: Mulfullon Orchard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JOHNS HOPKINS HOSPITAL

AUG 14 1923

Robert P. Harrison, Registrar

TYPE • A • E • P • E

Cor.—1-12-23—M&T—100 Bks.

D78317

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

177 D78317

1-PLACE OF DEATH

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. Mercy Hospital 12 WARD)

2-FULL NAME Hattie Brown Harbaugh

(a) RESIDENCE No. 337 Whitridge Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) July 22 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	0	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer) 069
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Fowlville Md

PARENTS

10 NAME OF FATHER Chas F Hartaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Alice M Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Russell Hartaugh
(Address) Waynesboro Pa

15 Filed AUG 14 1923, 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-14 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an .....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said .....(Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Bichloride Mercury Tablets

duration yrs. mos 10 ds.

(Signed) W K Grenat M. D.
(Coroner.)

8-14 1923 (Address) 117 W. Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fowlville, Md	Aug 16 1923
20 UNDERTAKER	ADDRESS
Wm J. Tickner & Sons	Balto Md

Registrar should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificate.

OAKLAND

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78318

CERTIFICATE OF DEATH.

74 001 D78318

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3300 Clifton ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Almira D. Barranger

(a) RESIDENCE NO. 3300 Clifton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. W. Barranger

6 DATE OF BIRTH (month, day, and year) Oct. 11, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Henry Rowe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary A. Amick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Miss Grace Hartelorne

(Address) 3300 Clifton Ave

15 Filed AUG 7 1923, 19 Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923, to Aug 13, 1923,

that I last saw him alive on Aug 13, 1923,

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) ds. mos. 13 ds.

18 Where was disease contracted if not at place of death? ,

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Lutz, M. D.

8/14 1923 (Address) 7040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Aug 16 1923
20 UNDERTAKER W. J. Nicholson & Sons	ADDRESS Florida

AUG 7 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78319

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-00D78319

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1227 S. Carey ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Manfred Von Lindenberg

(a) RESIDENCE NO. 1227 S. Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Von Lindenberg

6 DATE OF BIRTH (month, day, and year) Oct 27 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Fred. Von Lindenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs M. Von Lindenberg (Address) 1227 S. Carey St

15 Filed ....., 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

UG 141923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 9 ..., 1923, to Aug 13 ..., 1923, that I last saw h alive on Aug 11 ..., 1923, and that death occurred, on the date stated above, at 8 00 A M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Thrombosis Varicose leg.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) James K. Hooper M. D.

8 14, 1923 (Address) 346 E. 28

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 8/15 1923

20 UNDERTAKER Geo Leimbach & Son

ADDRESS 647 Fulton

U.S. MARK PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78320

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D78320

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hos. (ST.) 25 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Lewis

(a) RESIDENCE NO. 108 Park Ave. (ST.) Hilltilus Park (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	W.	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? ? ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	5-6 yrs. about			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver 23

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) Do not know.
(State or country)

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country)

14 Informant Harriet Lewis.
(Address) 108 Park Ave

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1923, to Aug 14, 1923,

that I last saw him alive on Aug. 14, 1923,

and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of? — —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical autopsy

(Signed) Karl Steinmueller, M. D.

8/14, 1923 (Address) 327 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Aug 16 1923

20 UNDERTAKER Wm Cook — ADDRESS 1021 Nash

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 14 1923

Robert P. Harrison
Registrar

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78321

CERTIFICATE OF DEATH.

113 D78321

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 S Washington St., 6 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Commings

(a) RESIDENCE No. 403 S Washington ST., 2 WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 months. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 11 -23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
0	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) ~~fdd~~

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Arthur Cummings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Elizabeth Fairbanks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbot Co Maryland

14 Informant Arthur Cummings (Address) 403 S Washington St

15 Filed AUG 15 1923 ROBERT A. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 14 1923

17 I HEREBY CERTIFY, That I attended deceased from August 14 1923. to 1923.

that I last saw him alive on August 14 1923.

and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

acute Pleurisy

or Cholera Infantum

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma Heart

(duration) yrs. mos. 3 months

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas L Simms M. D.

19 (Address) 1025 N Wolfe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem

DATE OF BURIAL 8/15 1923

20 UNDERTAKER Frederick W. Ozazuski

ADDRESS 1985 Eastern Ave

N. B.—Whatever information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78322

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 331 N. Stricker St. 19 159 Ward)

Registered No. C. D78322

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Warren A. H. Brown

(Residence in Baltimore: No. 331 N. Stricker St. St.; yrs. mos. 6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	colored	Single

6-DATE OF BIRTH. August 5 1923
(Month) (Day) (Year)

7-AGE. ..... yrs. ..... mos. 6 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. John A. Brown

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Emma Warren

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John A. Brown

(Address) 331 N. Stricker

15-

Filed AUG 15 1923 ROBERT R. KRAUER, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. August 14, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Status Lymphaticus

(Duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Aug 15 1923 (Address) 2600 Eutaw Place

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death. .... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	Aug 15 1923
20-UNDERTAKER. Sam'l W. Black	ADDRESS 1400 Madison

R. S.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D78323

REGISTERED NO.

D78323

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 343 S. Calhoun ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Fiel

(a) RESIDENCE NO. 343 S. Calhoun St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 29, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		4	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Charles E Gill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Dorothy Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Charles E Gill
(Address) 343 S Calhoun St

15 Filed AUG 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/13 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Heat Prostration (duration) yrs. mos. ds.

(Signed) H T Gorsel, M. D. (Coroner.)

8-14, 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem — DATE OF BURIAL 8-15 1923

20 UNDERTAKER Robt Brooks & Son — ADDRESS Calhoun & Baltimore Sts

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D78324

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D78324

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 809 N. North ave ST., 14 WARD)

2-FULL NAME Samuel Brenner

(a) RESIDENCE No. 809 N. North ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Brenner

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery 034

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Laib Brenner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Freida Foster

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Levis 1439 Eastaw

15 Filed AUG 15 1923, 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-14 1923

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1923, to Aug 14, 1923, that I last saw him alive on Aug 14, 1923, and that death occurred, on the date stated above, at 8:30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) secondary Lymphosarcoma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Pathological section

(Signed) C B Brennard, M. D.

8/15 1923 (Address) 204 N Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrem Rosedale — DATE OF BURIAL 8/15 1923

20 UNDERTAKER Jack Levis 1439 Eastaw — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(See affadiret over)

D78325

D78325

49

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Hebrew Hospital (ST.) 6 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Steinberg

(a) RESIDENCE. No. 12 N. Montford Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? 13 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Leah Steinberg

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 44 50 | Months — | Days — | If LESS than 1 day, hrs. nr min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoe Maker 088

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Lahel Steinberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Bessie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 E 13 Balto

15 Filed AUG 15 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14, 1923

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to Aug 14, 1923, that I last saw him alive on Aug 14, 1923, and that death occurred, on the date stated above, at 7:10 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Malignancy

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) Isidore D. Jug, M. D.

8/14 1923 (Address) Hebrew Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Hessing Rm — DATE OF BURIAL: 8/15 1923

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balto

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 20 1923

Personally appeared before me on Aug 20-1923
Mr Jack Lewis who made affadavit
that the age given on Death Certificate
D 78325. should be 44 years
instead of 50. yrs.

Seal Jack Lewis

Seal George H Greer
Notary Public

valvular heart disease;
, etc. The contributory
) affection need not be
ample: *Measles* (disease
nchopneumonia (second-
re symptoms or terminal
nia," "Anemia" (merely
Collapse," "Coma," "Con-
genital," "Senile," etc.),
Heart failure," "Hemor-
us," "Old age," "Shock,"
, when a definite disease
use. Always qualify all
birth or miscarriage, as
PUERPERAL *peritonitis*,"
surgical operation was
DEATHS state MEANS OF
CCIDENTAL, SUICIDAL, or
such, if impossible to
ples: *Accidental drown-*
ain—accident; Revolver
poisoned by carbolic acid
ature of the injury, as
sequences (e. g., *sepsis*,
er the head of "contribu-
on statement of cause of
tee on Nomenclature of
ciation.)

URTHER STATEMENTS
CIAN.

(name origin; "Cancer" is less definite; avoid use of
"Tumor" for malignant neoplasms); *Measles*;

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78326

D78326

10

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

2-FULL NAME William Gerrain.

(a) RESIDENCE NO. 1206 Wilcox St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 18 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none (child)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER William Gerrain

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md

12 MAIDEN NAME OF MOTHER Marg. Murphy

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant William Gerrain (Address) 1206 Wilcox St.

15 Filed ..... 19 ..... Registrar

AUG 15 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/14/23

17 I HEREBY CERTIFY, That I attended deceased from aug 12, 1923, to aug 14, 1923, that I last saw him alive on aug 13, 1923, and that death occurred, on the date stated above, at 3:02 A. m.

The CAUSE OF DEATH* was as follows:

Diphtheria, nasal, tonsillar, pharyngeal & laryngeal

(duration) — yrs. — mos. 6 da.

CONTRIBUTORY (Secondary) Myocarditis (duration) — yrs. — mos. 24 da.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Culture (+)

(Signed) Bluefarb M. D.

8/14/1923 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Aug 14 1923

20 UNDERTAKER E. A. Wiedefeld & Co ADDRESS 501 E 22 St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

D78327

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

-X 113 ✓ D78327

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 635- Bond 21- ST.: 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geraldine Washington

(Residence in Baltimore: No. 635- Bond St.; ..... yrs., 1 mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
F	C	

6-DATE OF BIRTH, March 1, 1923 (Month) (Day) (Year)

7-AGE, ...yrs. 5 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Penna.

PARENTS.

10-NAME OF FATHER, Will White

11-BIRTHPLACE OF FATHER (State or Country), Pendora Washington

12-MAIDEN NAME OF MOTHER Leather ~~Ward~~ Washington

13-BIRTHPLACE OF MOTHER (State or Country), Washington

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Elliott

(Address) 1720 E Ashland Ave

15- Filed ....., 191.... ROBERT R. KRAUTER, Registrar.

AUG 15 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 14, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 13 1923, to Aug 14 1923, that I saw her alive on Aug 13 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum evidently for 2 or 3 days

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) ....yrs. ....mos. ....ds.

(Signed) R. J. Young M. D.

8/14, 1923 (Address) 1429 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Valley Lee	Aug. 15, 1923
20-UNDERTAKER Mrs Robert Fleck	ADDRESS 1725 E Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

D78328

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

D78328

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 146 Wilson St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaretha Gisabelle Duchstein

(a) Residence No. 146 Wilson St., Ward

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 64 yrs. 1 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (Write the word.)

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Wm H Duchstein

6-DATE OF BIRTH (month, day and year) Jan 23 1846

7-AGE, 77 yrs. 6 mos. 21 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Philadelphia

PARENTS.

10-NAME OF FATHER, Joseph C Payett

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Philadelphia

12-MAIDEN NAME OF MOTHER, Martha James

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Conglewood

14-INFORMANT, Jamie Helen Duchst.

(Address) 146 Wilson St

15-FILED AUG 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 13 1923

17-I HEREBY CERTIFY, That I attended deceased from July, 1922, to Aug 13, 1923, that I last saw h.. alive on Aug 13, 1923, and that death occurred, on the date stated above, at 11 45 p.m.

The CAUSE OF DEATH* was as follows:

Acute Coronary Obstruction

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Standish McClung M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL, Aug 16, 1923

20-UNDERTAKER, Louis Heumann — ADDRESS 32 S Broadway

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1925-30
1978329

CERTIFICATE OF DEATH.

38 D78329

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Brown

(a) RESIDENCE NO. 1440 N. Mount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ~~[illegible]~~ Life yrs. ~~[illegible]~~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) May 11-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Alice Diggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Records. (Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 15 1923 19 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 3, 1923, to Aug 14, 1923, that I last saw h alive on Aug 14, 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Syphilis

(duration) yrs. Life mos ds.

CONTRIBUTORY (Secondary) Acute Nephritis - 3 weeks.

(duration) yrs. mos. Bronchopneumonia - 12 hours ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Wassermann: Positive.

(Signed) A. A. Reed, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 8/16 19 23

20 UNDERTAKER Jos. F. Rund — ADDRESS 120 Gleve[illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

078330

CERTIFICATE OF DEATH.

078330

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 St. Lanvale St. 17 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Payne.

(a) RESIDENCE. No. 521 St. Lanvale ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of H. M. H. Payne

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer [illegible]

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Birtha Scott

(Address) 521 St. Lanvale St.

15 Filed AUG 15 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1923, to Aug 13, 1923, that I last saw her alive on Aug 13, 1923, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Thos D Woodruff, M. D.

8/15, 1923 (Address) 523 N Eutaw the same

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bth Cem	8/16 1923
20 UNDERTAKER Jas N Davis	ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D78331

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78331

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Or Pister Kirchuk Registered No.....

City of BALTIMORE: (No. Municipal Hospital St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Karcheck Pister Korneyczuk

(a) Residence No. 421 Ostend St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): 1878

7-AGE. 45 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Poland

PARENTS.

10-NAME OF FATHER: Evan Karcheck

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: Ula ?

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

11-(Informant) Municipal Hospital Records.
(Address)

15-Filed AUG 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): August 13, 1923

17- I HEREBY CERTIFY, That I attended deceased from July 3 1923 to August 13 1923 that I last saw him alive on August 13 1923 and that death occurred, on the date stated above, at 8:10 P.M.

The CAUSE OF DEATH* was as follows:

Syphilitic Aortitis
Aortic Insufficiency
Cardiac Failure

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Lab. & X-ray

(Signed) Claude G. Drew M. D

8-14 1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Aug. 15 1923

20-UNDERTAKER: John Grebliauskas — ADDRESS: 425 S. Forest St.

Physician to carefully supply ALL items called for. Cause of death must be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78332

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001
D78332

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. 1048 Vine St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Forland

(Residence in Baltimore: No. 1048 Vine St. yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.)

6-DATE OF BIRTH, ... (Month) ..... (Day) 1840 (Year)

7-AGE, 83 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)..... 041

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, John Lee

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER, Dont know.

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hester Lee

(Address) 620 N. Bruce St.

15-

Filed AUG 15 1923 192.. ROBERT R. KRAUTH Registrar

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug - 12 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Senile Bronchitis

7 (Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Organic Heart Disease

1 (Duration) yrs. mos. ds.

(Signed) ..... M. D.
(Coroner.)

Aug 14 1923 (Address) 4336 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Mt Auburn C. Aug 15 1923

20-UNDERTAKER. ADDRESS.

Brown Ireland & Schroeder

R. S. — Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78333 44 D78333

CERTIFICATE OF DEATH.

D78333

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2024 Cliftwood Av ST., 8 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H. Budde

(a) RESIDENCE NO. 2024 Cliftwood Av ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Catherine Budde

6 DATE OF BIRTH (month, day, and year) Aug 9/64

7 AGE — Years: 54 — Months: — — Days: 3 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Wood Moulder

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer: Levinson & Zenitz

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Wm Budde

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Catherine Budde
(Address): 2024 Cliftwood Av

15 Filed AUG 15 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1923

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1923, to Aug 12, 1923, that I last saw h[illegible] alive on Aug 12 1923 and that death occurred, on the date stated above, at 3.05 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma - Oesophagus

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter W White Jr. M. D.

8/13. 1923 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cem.

DATE OF BURIAL: 8/15 1923

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Orleans St

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78334

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78334

CERTIFICATE OF DEATH.

6 188-003

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Johns Hopkins Hospital St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Greb of C.

(Residence in Baltimore: No. 15 N Ellwood Ave St.; yrs. 54 mos. 2 ds. 12)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX,	4-COLOR OR RACE,	5-Single, Married, Widowed, Divorced. (Write the word.)
male	white	Widower

6-DATE OF BIRTH, June 1st/ 1869 (Month) (Day) (Year)

7-AGE, 54 yrs. 2 mos. 12 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Clothind Mfg

009

9-BIRTHPLACE, (State or Country), Balto. Md

PARENTS.

10-NAME OF FATHER, Chas. Greb

11-BIRTHPLACE OF FATHER, (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Catherine xxxxxxx

13-BIRTHPLACE OF MOTHER, (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. W. Greb (son)

(Address) 3511 Benson St.

15- Filed AUG 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 13/23 (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest to be held (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) inquest find that said deceased came to n/a death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck by Automobile-
Fractured Skull, Rt. Leg & Ribs on left side

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Hall M. D. (Coroner.)

8/13/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Carmel	8/16 1923
20-UNDERTAKER.	ADDRESS
Philip Herring	2016 Orleans

Space below for information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D78335

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D78335

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) 315 N. Bryce ST. 70 WARD)

2-FULL NAME Lannie Smith

(a) RESIDENCE NO. 315 N. Bruce ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard Smith

6 DATE OF BIRTH (month, day, and year) Sept ? 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	11	?	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seamstress
(b) General nature of industry, business, or establishment in which employed (or employer) Shirt Factory
(c) Name of employer ? Winchester Mfg Co

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Edward Segar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Essex Co. Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Essex Co. Va

14 Informant Howard Smith (Address) 315 N Bruce St

15 Filed AUG 15 1923 19 ROBERT R. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1923, to Aug 12, 1923, that I last saw h.w alive on Aug 10, 1923 and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis? Sputum Test

(Signed) J. McRae, M. D.
8/13 1923 (Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

20 UNDERTAKER — ADDRESS

Druid Hill

GIVE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78336

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78336

442

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Hayes

(a) RESIDENCE NO. 631 Sarah Ann St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Deck Hand

(b) General nature of industry, business, or establishment in which employed (or employer) 0 ↓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew Hayes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Emma Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Municipal Hospital Records.

(Address)

Filed AUG 15 1923 H. Lane Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 13 1923

17

I HEREBY CERTIFY, That I attended deceased from August 10, 1923, to August 13, 1923,

that I last saw him alive on August 12, 1923,

and that death occurred, on the date stated above, at 4:00 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach -

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) General carcinomatosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes - Date of Aug. 11-1923

Was there an autopsy? Yes -

What test confirmed diagnosis? Autopsy & Operation

(Signed) Anthony V Bucholens, M. D.

8-13-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mathias Co. ↓	aug 15 1923
20 UNDERTAKER	ADDRESS 631
Edward Bryson	Orleans st

•CAUSE OF DEATH is very important. See instructions on back of certificates.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPA-

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78337

CERTIFICATE OF DEATH.

144

REGISTERED NO. D78337

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1503 N. Regester ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Cox

(a) RESIDENCE. NO. 1503 N. Regester ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 14-1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	9	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thos. F. Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary B. Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Catherine A. Cox
(Address) 1503 N. Regester St.

15 Filed ... 19 ... Registrar

AUG 15 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug. 1st, 1923, to Aug. 13, 1923, that I last saw him alive on Aug 13, 1923, and that death occurred, on the date stated above, at 4.10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
(Cardiac End)

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) ...
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Philibert Antzjanni, M. D.

, 19 (Address) 294 E Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	8/16/23

20 UNDERTAKER ADDRESS

H. C. Wedefeld 914 Guilford Ave

N. B.—WRITE LEGIBLY. ALL ENTRIES REGARDING DATE OF BIRTH, AGE AND PLACE OF BIRTH SHOULD BE CAREFULLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78338

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78338

CERTIFICATE OF DEATH.

1295

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2701 Allen Ave ST., 15 WARD)

2-FULL NAME Mary A Ackman

(a) RESIDENCE NO. 2701 Allen Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John S Ackman

6 DATE OF BIRTH (month, day, and year) July 15 th 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	58	—	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Flood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs John S Ackman

(Address) 2701 Allen Ave.

15 Filed AUG 15 1923 17 Ave. Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 th 1923

17

I HEREBY CERTIFY, That I attended deceased from July 27, 1923, to Aug 13, 1923, that I last saw h alive on Aug 12, 1923 and that death occurred, on the date stated above, at 11:30 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(duration) yrs. mos 2 1 ds.

CONTRIBUTORY (Secondary) Chr. Parenchymatous Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) James Brown, M. D.

8/14 1923 (Address) 1837 Penna ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Aug 16 1923
20 UNDERTAKER	ADDRESS
John F J Cowan & Son	901 Hollins
per F J Cowan	

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78339

100-001

CERTIFICATE OF DEATH.

D78339

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 368 N. Gay St ST., 5 WARD)

2-FULL NAME Theresa Hope DiPaula.

(a) RESIDENCE NO. 368 N. Gay St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 Single, Married, Widowed, or Divorced, (Write the word) Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 9-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Victor DiPaula

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Edna M. Cross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Victor DiPaula

(Address) 368 N. Gay St

15 Filed AUG 15 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1923, to Aug 14, 1923

that I last saw her alive on Aug 14, 1923

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Primary Broncho-Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Luigi D. DiStefano M. D.

Aug 15, 1923 (Address) 407 N. Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent Cem.	8/15/23

20 UNDERTAKER	ADDRESS
Geo. J. Roth	1725 Harford Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Graver

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78340

CERTIFICATE OF DEATH.

74-001

D78340

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 308 Park ave ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Graver

(a) RESIDENCE NO. 308 Park ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 25-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	77	7	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... None-
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer —

9 BIRTHPLACE (city or town) ..... Pa
(State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) — y
(State or country)

12 MAIDEN NAME OF MOTHER Kreiger

13 BIRTHPLACE OF MOTHER (city or town) ..... Pa
(State or country)

14 Informant Alice Carledge
(Address) 308 Park Ave

15 Filed ..... 192 .....
Registrar

AUG 15 1923 ROBERT P. KRAUTER

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-14 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(Inquest, autopsy or inquiry.)~~ inquiry.)
thereon and from the evidence obtained by said ~~Inquest, autopsy or inquiry.)~~ Inquest, find that said deceased came to ~~his~~ her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy
a few minutes
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Dont Know
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W H Joseph, M. D.
(Coroner.)

8-15, 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Philadelphia Pa.

DATE OF BURIAL Aug 15 1923

20 UNDERTAKER W. M. Routzon

ADDRESS 2238 N North

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78341

CERTIFICATE OF DEATH.

100-001 D78341

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1400 N. Montford Ave ST.; 8 WARD)

2-FULL NAME Mary Elizabeth Schulz

(a) RESIDENCE. No. 1400 N Montford ST., 8 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, ~~widowed~~, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of Albert B Schulz

6 DATE OF BIRTH (month, day, and year) June 19 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
78	78	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): ooo

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER H F Hulsman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER Mary E Prenger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant C J Kane

(Address) 1406 n montford ave

15 Filed AUG 15 1923 ROBERT R. ... Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 12 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1923, to Aug 12, 1923, that I last saw her alive on Aug 12, 1923, and that death occurred, on the date stated above, at 630 a. m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) — Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? none

What test confirmed diagnosis?

(Signed) P S Herzog M. D.

Aug 13, 1923 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Royal Cemetery — DATE OF BURIAL: 8/13 1923

20 UNDERTAKER: Wm J Luhrs Sons — ADDRESS: 131 E Biddle St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-13—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78342 — 31 — D78342

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1317 Annapolis av ST.: 21 WARD)

2-FULL NAME George Hartheimer Sr

(a) RESIDENCE. No. 1317 Annapolis av ST., 21 WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Hartheimer

6 DATE OF BIRTH (month, day, and year) Dec 6 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Geo Hartheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Stein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Minnie Hartheimer
(Address) 1317 Annapolis av

15 Filed ... 19 ... James E. Harrison, Registrar

AUG 15 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 1923 to Aug 13 1923

that I last saw him alive on Aug 11 1923

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. M. Kieffer, M. D.

Aug 14 23 19 (Address) 2320 Rand Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Aug 16 1923
20 UNDERTAKER	ADDRESS 1084
E Richmond Son	Monroe St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
TION is very important. See instructions on back of certificates.

D78343

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78343

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mary Hospital St. 13 79 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Jane Bosh

(Residence in Baltimore: No. 1329 Weldon av St.; 7 yrs. 3 mos. 9 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	white	Single

6-DATE OF BIRTH. May 5 1916
(Month) (Day) (Year)

7-AGE, 7 yrs. 3 mos. 9 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): 000

9-BIRTHPLACE, (State or Country): Balto

PARENTS.

10-NAME OF FATHER. Geo. B Bosh

11-BIRTHPLACE OF FATHER, (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Kate Ebert

13-BIRTHPLACE OF MOTHER, (State or Country). Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Bosh

(Address) 1329 Weldon av

15-

Filed ..... 192.....

Registrar.

AUG 15 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 13 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns - acute toxemia
as sec'd from bon fire
7 hrs (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. H. Kelly M. D.
(Coroner.)
Aug 13 1923 (Address) 1659 Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St Mary's Lambdin	Aug 16 1923

20-UNDERTAKER. Horace A Burgee ADDRESS 363 Hall's Rd

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78344

CERTIFICATE OF DEATH.

D78344

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2118 Walbrook ave ST.; 15 WARD) (REGISTERED No. C 61)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME None. Premature child. B-by Krauss

(Residence in Baltimore: No. 2118 Walbrook ave St.; 0 yrs., 0 mos. 1/6 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~ (Write the word.)

6-DATE OF BIRTH, Aug. 15 (Month) (Day), 1923 (Year)

7-AGE, — yrs. — mos. 1/6 ds.

If LESS than 1 day, 4 hrs. or — min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) — 000

9-BIRTHPLACE, (State or Country) 2118 Walbrook ave

PARENTS.

10-NAME OF FATHER, Ferdinand Kammerer Jr.

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Catherine Krauss

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C.W. Hoffman, MD

(Address) 2100 W. North ave.

15-

Filed ....., 191.....

AUG 15 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 15 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1923, to Aug 15 1923, that I saw her alive on Aug 15 1923, and that death occurred, on the date stated above, at 8. a. m.

The CAUSE OF DEATH* was as follows:

Premature infant- 7 months gestation.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C.W. Hoffman M. D.

Aug 15, 1923. (Address) 2100 W. North ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Olivet Cemetery

DATE OF BURIAL. Aug. 16, 1923

20-UNDERTAKER W. M. Routson

ADDRESS 2238 W North ave

A.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78345.

CERTIFICATE OF DEATH.

90 D78345

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 N Green St ST., 17 WARD)

2-FULL NAME James Centineo

(a) RESIDENCE NO. 407 N Green St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Francis

6 DATE OF BIRTH (month, day, and year): 1833

7 AGE: Years 90; Months; Days; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 045

(b) General nature of industry, business, or establishment in which employed (or employer): Fruit Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Antonio

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Antonia

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Joseph Centineo

(Address) 407 N Green St

15 Filed ..... 19 ..... Registrar

AUG 15 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8-12 1923

17

I HEREBY CERTIFY, That I attended deceased from 8-10 .1920. to 8-12 .1923

that I last saw him alive on 8-10 .1923

and that death occurred, on the date stated above, at 1.30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis - Cardiac decompensation + valvular disease of heart (duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Hemiplegia - (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical -

(Signed) S. Demarest, M. D.

8-15 1923 (Address) 1004 Lindsay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: Aug 16 1923

20 UNDERTAKER: Martin Fahey & Son — ADDRESS: 182 W North

...MATION, WHICH CANNOT BE ...
...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE
TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78346

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78346

CERTIFICATE OF DEATH.

113

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3702 E. Lombard ST., 26 WARD)

2-FULL NAME Verna Patterson

(a) RESIDENCE No. 3702 E. Lombard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/19/22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.
		7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Clarence Patterson

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Daisy McDonald

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Clarence Patterson
(Address) ~~3702 Lombard St~~

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/14/ 19 23

17 I HEREBY CERTIFY, That I attended deceased from 8/13/23, 19..., to 8/14/23, 19...,

that I last saw her alive on 8/13/23, 19...,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

Sixty 3 wks.
(duration) yrs. mos ds.

CONTRIBUTORY —
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Pt. at Balto. Gen'l, Wassermann

(Signed) Bernard Fox, M. D.

8/15, 19 23 (Address) 1124 E. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL

St Mary's Hampden Aug 16 19 23

Undertaker CHENOWETH & SON, ADDRESS

3617 CHESTNUT AVE.

AUG 15 1923

Robert F. Garrison,
Local Health Clerk.

N.B.—WRITE PLAINLY, WITH CRAYON OR INK. ALL items of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78347 — 38 — D78347

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 Falls Road St.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Helen Miller

(a) RESIDENCE. No. 1014 Falls Road WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (Write the word)
Female	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 21 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	7	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) 030
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MD

PARENTS

10 NAME OF FATHER Pierce S Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) MD

12 MAIDEN NAME OF MOTHER Elsie Amarant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) MD

14 INFORMANT Pierre Miller
(Address) 1014 Falls Road

15 Filed AUG 15 1923, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 1923, to Aug 14, 1923, that I last saw her alive on Aug 14, 1923, and that death occurred, on the date stated above, at 4.30 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Palsy - Hemiplegia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Convulsions - Intestinal Tumor (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frollwe H Bond, M. D.

8/16/23 (Address) 2020 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	aug 16 1923

20 UNDERTAKER Chenaweth & Son ADDRESS 3615 Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Lustic

Spec.—1-10-21—M&T—1500 Blks.

D78348

HEALTH DEPARTMENT—CITY OF BALTIMORE

O.K. W.K. Gooch
TH-001 Cor. M. District
D78348

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3208 Frederick Ave ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Saunders

(a) RESIDENCE NO. 3208 Frederick Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha J. Saunders

6 DATE OF BIRTH (month, day, and year): Aug 28 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	65	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired.

(b) General nature of industry, business, or establishment in which employed (or employer): ~~[illegible]~~

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): ~~England~~ Md

PARENTS

10 NAME OF FATHER: James H. Saunders

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Amelia Conklin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Charles H. Saunders Jr.
(Address): 3208 Frederick Ave

15 Filed ..... 19 ..... Registrar

AUG 15 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 14th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 14 1923 to Aug 14 1923, that I last saw him alive on ..... 19 ....., and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Paralysis (duration) 8 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) L. L. Gordy M. D.

8-14, 1923 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Aug 17th 1923

20 UNDERTAKER: Wm Cook

ADDRESS: 502 E North Ave

WRITE PLAINLY, WITH UNFADING INK. Every item should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78349

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-01 D78349

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 531 S. Ann ST., 7 WARD)

2-FULL NAME Raymond Robert Francis Mc. Lewee.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 531 S. Ann. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 5 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	2	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Robert Mc. Lewee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Francis Rutkowski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Robt. Mc Lewee

(Address) 531 S Ann.

15 Filed AUG 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1923, to Aug 14, 1923, that I last saw h[illegible] alive on Aug 14, 1923, and that death occurred, on the date stated above, at 8.30 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Oedema of the Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) Benjamin Pushkin, M. D.

1923 (Address) 1804 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — DATE OF BURIAL: Aug 17 1923

20 UNDERTAKER: John A. Moran 3000 — ADDRESS: E. Baltor[illegible]

N. B.—[illegible] should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

S. A. FEE

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78350

CERTIFICATE OF DEATH.

154 D78350

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2742 W. Baltimore ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Stavros.

(a) RESIDENCE. NO. 2742 W. Baltimore ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 11. 1923

7 AGE — Years — Months — Days: 5 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Chas. Stavros

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece.

12 MAIDEN NAME OF MOTHER Jamie Likis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Haven, Conn

14 Informant Jennie Stavros

(Address) 2742 W. Balto.

15 Filed AUG 16 1923, 19 ROBERT R. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 11, 1923, to Aug 15, 1923, that I last saw her alive on Aug 14, 1923, and that death occurred, on the date stated above, at 2=A m.

The CAUSE OF DEATH* was as follows:

Failure of Foramen Ovales

& Close (duration) from birth ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm. H. Seabury, M. D.

8/15 1923 (Address) 638 Fort

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Aug 16 23

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 1531 W. Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DAK

KO

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78351 D78351

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Bertha Dill

(a) Residence No. Bare Hills Blvd West Wash. Md Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	colored.	married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles (?)

6-DATE OF BIRTH (month, day and year) 1882

7-AGE. 41 yrs. mos. ds. If LESS than 1 day, hrs. or. min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None (one)

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, Modesin Dill.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Josephine Blair

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Hospital Records

(Address).....

15- Filed AUG 16 1923 ROBERT R. KRAUTER Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 15-23

17- I HEREBY CERTIFY, That I attended deceased from 7/27/23, 19.. to 8/15/23, 19.. that I last saw h[illegible] alive on 8/15/23, 19.. and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. W. Holley M. D.

, 19 (Address) Mercy

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL St Patricks — DATE OF BURIAL. Aug 16, 19 23

20-UNDERTAKER. Mc Mech & Frick — ADDRESS 1737 N Paca St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78352

CERTIFICATE OF DEATH.

118-00 ✓ D78352

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1417 Belvedere ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Calvin Adams

(a) RESIDENCE NO. 1417 Belvedere ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? N/a yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband

6 DATE OF BIRTH (month, day, and year) Autumn

7 AGE 74 Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N C

PARENTS

10 NAME OF FATHER Calvin Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Lorenzo Hagan

(Address) 1417 Belvedere St-Balt.

15 Filed AUG 16 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 13 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 10, 1923, to Aug 13, 1923, that I last saw him alive on Aug 13, 1923, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Obstruction of Intestines or Intestinal Obstruction

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Constipation

(duration) yrs. 7 mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo P Hall M. D.

, 19 (Address) 926 E 23rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Aug 16 19
20 UNDERTAKER Mrs Robert E Elliott	ADDRESS 1125 Ashland Ave

N. B.—WHITE PAPER, WITH ONE CARBON COPY, FURNISHED FREE. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78353

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1117

112

D78353

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 335 Bresteman ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella V. Rauch

(a) RESIDENCE. NO. 335 Bresteman ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 26 1870 Unknown 1870.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse.

(b) General nature of industry, business, or establishment in which employed (or employer) 048

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore. Md

PARENTS

10 NAME OF FATHER John H Rauch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Jane Bowen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs M. E. Boulden

(Address) 335 Bresteman St

15 Filed AUG 16 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Augt 15. 1923

17

I HEREBY CERTIFY, That I attended deceased from Augt 15, 1923, to Augt 15, 1923, that I last saw h er alive on Augt 15, 1923, and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation - about 1/2 hour duration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ac. Indigestion about 7 hrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 0132

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Diagnosis

(Signed) F W Keown, M. D.

8/15/1923 (Address) 1938 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Aug 17 1923
20 UNDERTAKER	ADDRESS
John B. Spencer	1325 N Caroline St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Emergency call at 2 A.M. - found patient in collapse - cold sweat - shortness of breath, blue lips, pulled & pinched face & pain in Epig. stomach & very weak pulse. History said was taken sick at supper - after eating peaches so. vomited & was very uncomfortable until she called me ! at 2 A.M. - I administered stimulants by hypo. had hot foot bath - mustard ov. until she died at 2.30 A.M.

J. W. Keaver M.D.

Cor.—1-12-23—M&T—100 Bks.

Vincent - Kaminskas ✓ 003

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78354

CERTIFICATE OF DEATH.

188-003 D78354

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Vincent Kaminskas

(a) RESIDENCE NO. 659 W Pratt ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 8-12-1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	6		2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto city
(State or country)

PARENTS

10 NAME OF FATHER Vincent Kaminskas

11 BIRTHPLACE OF FATHER (city or town) Lithuania
(State or country)

12 MAIDEN NAME OF MOTHER Apulaquite

13 BIRTHPLACE OF MOTHER (city or town) Lithuania
(State or country)

14 Informant Vincent Kaminskas
(Address) 659 W Pratt Pratt

15 Filed AUG 16 1923, 19... ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 14 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull & internal injuries

(duration) yrs. mos. 3 hrs ds.

CONTRIBUTORY (Secondary) Struck by Auto

(duration) yrs. mos. ds.

(Signed) W R Jarrell M. D.
(Coroner.)

8/16, 192 3 (Address) 117 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	8/17/23
20 UNDERTAKER	ADDRESS
J M Gubbinckers	425 S Pace

Instructions should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78355

CERTIFICATE OF DEATH.

90 D78355

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2035 McCulloh ST. 14 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ella Redwick

(Residence in Baltimore: No. 2035 McCulloh St.; 20 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.): Widowed

6-DATE OF BIRTH, Feb 8, 1881 (Month) (Day) (Year)

7-AGE, 42 yrs. 6 mos. 6 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Maid
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Eastern Shore Md

PARENTS.

10-NAME OF FATHER, Wilson Wells

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Lucy Slaughter

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Wells

(Address) 2035 McCulloh St

15- AUG 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk

Filed....., 191.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 14, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 30 1923, to Aug 14 1923, that I saw h[illegible] alive on Aug 14 1923, and that death occurred, on the date stated above, at 10:25 P.M.

The CAUSE OF DEATH* was as follows: Valvular heart lesion

(Duration) Chronic ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. J. Coleman M. D.

Aug 16, 1923 (Address) 2038 McCulloh

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Rapple Md — DATE OF BURIAL, Aug....., 191...

20-UNDERTAKER Samuel S. Kunkel — ADDRESS Reisterstown

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D78356

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Registered No. C 90 D78356

1-PLACE OF DEATH

City of BALTIMORE: (No. 503 North Calvert St or Mary Lowe Asylum St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Kerr

(Residence in Baltimore: No. 613 N. Calvert St. (yrs. 41 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Married

6-DATE OF BIRTH. ..... (Month) ..... (Day) ..... (Year)

7-AGE. 52 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION.
(a) Trade, profession, or particular kind of work: Worked in Turkish Bath Place
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9-BIRTHPLACE. (State or Country). England.

PARENTS.

10-NAME OF FATHER. W. Kerr

11-BIRTHPLACE OF FATHER. (State or Country). Scotland

12-MAIDEN NAME OF MOTHER. Rickin

13-BIRTHPLACE OF MOTHER. (State or Country). England.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sara B. Kerr

(Address) 5303 Elsinore Way

15- Filed AUG 16 1923 ROBERT R. KRAUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. July (Month) 14 (Day) 23 192 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular disease heart.

Dont Know (Duration) did suddenly. yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage probably

(Duration) yrs. mos. ds.

(Signed) H. T. Tuley M. D.

(Coroner)

Aug 16 1923 (Address) 1639 Broadway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Druid Ridge	Aug 16 1923
20-UNDERTAKER.	**ADDRESS**
Geo G. Booth	Mathews Hanford

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78357

77x

D78357

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt. Hope Retreat ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Dolorick John Danilovich

(a) RESIDENCE. NO. Lansdowne P.O. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 7 ds. How long in U. S., if of foreign birth? about 23 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergyman — Rom

(b) General nature of industry, business, or establishment in which employed (or employer) Parish Priest

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Not Known Austria

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Records of Mt Hope Retreat (Address) Baltimore Md

15 Filed AUG 16 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 7th, 1923, to Aug 15, 1923.

that I last saw him alive on Aug 15, 1923,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Acute Manic depression

To My Knowledge

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Intestinal paresis

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? At this home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Charles J. Peter, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gettysburg Penna — DATE OF BURIAL Aug 16 1923

20 UNDERTAKER STEWART & MOWEN [redacted] E. WOODEN, Successor — ADDRESS [redacted] W. Fayette St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

078358 114 D78358

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1828 Bell St., 24 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Vermillion

(a) Residence No. 1828 Bell St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 5 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced (Write the word.)
female	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Febry 19

7-AGE. 7 yrs. 5 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS:

10-NAME OF FATHER Frank Vermillion

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER Elma Cooke

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto Md

14-

(Informant) Mr Frank

(Address) 1828 Bell St.

15-

Filed AUG 16 1923 Rec'd ..... ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 16th 1923

17- I HEREBY CERTIFY, That I attended deceased from August 7, 1923 to August 16, 1923

that I last saw her alive on August 15, 1923

and that death occurred, on the date stated above, at 2a m.

The CAUSE OF DEATH* was as follows:

Ilio Colitis

(Duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Convulsions

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw V Cooke M. D.

8/16, 1923 (Address) 24 N. Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Mt Carmel Cem	Aug 18 1923
20-UNDERTAKER. John J Cowan & Son Per J J Cowan	ADDRESS 901 Hollins St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78359

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D78359

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 45 N Paphlion ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriett Eva Elliott

(a) RESIDENCE No. 45 N Paphlion ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			26 mos	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Victor Wallace Elliott

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Annie Elizabeth Wood

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Calvert Co Md

14 Informant Edna B. Elliott
(Address) 45 N Paphlion Ave

15 Filed AUG 16 1923 19 ROBERT R. KRAUTER Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 14, 1923, to Aug 15, 1923, that I last saw h[illegible] alive on Aug 15, 1923, and that death occurred, on the date stated above, at 4-PM

'The CAUSE OF DEATH' was as follows:

Premature birth

Cause of Mother

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature birth

(duration) yrs. mos. 26 ds

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 16 1923
20 UNDERTAKER Edwin Cowan & Son	ADDRESS Jos Hollins
Per W. J. Cowan	

mation should be carefully supplied. AGE should be stated EXACTLY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

82 D78360

D78360

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH Mrs Hope Richards

CITY OF BALTIMORE: (No. Baltimore Md ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Tyson

(a) RESIDENCE. NO. Emmitsburg, Md ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred abt 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed.

6 DATE OF BIRTH (month, day, and year) Aug 10, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	-	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Emmitsburg Md

PARENTS

10 NAME OF FATHER William Tyson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Emmitsburg Md

12 MAIDEN NAME OF MOTHER Teresa Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Emmitsburg Md

14 Informant Mrs Hope Richards.

(Address)

15 Filed ..... 19 ..... Registrar

AUG 16 1923 ROBERT R. KRAUTER, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1923, to Aug 13, 1923, that I last saw him alive on Aug 15, 1923, and that death occurred, on the date stated above, at 12.30 A. m.

The CAUSE OF DEATH* was as follows:

Multiple neuritis

(duration) 4 yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Senile Marasmus duration unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Emmitsburg Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Milton O Hall, M. D.

, 19 (Address) Taylor - Rockville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmitsburg Md	Aug 16 1923

20 UNDERTAKER Chas G. Black ADDRESS 742 W. Pratt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78361

CERTIFICATE OF DEATH.

49

D78361

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 221 S. Broadway ST.; 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John S. Smith

(Residence in Baltimore: No. 221 S. Broadway St.; ....yrs.,....mos.....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, January (Month) 29 (Day), 1890 (Year)

7-AGE, 33 yrs. 6 mos. 16 da.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Life Insurance agent
(b) General nature of industry, business, or establishment in which employed (or employer)..... 671

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, John S. Smith

11-BIRTHPLACE OF FATHER (State or Country), Queen Anne Co

12-MAIDEN NAME OF MOTHER Ruth E. Parks

13-BIRTHPLACE OF MOTHER (State or Country), Queen Anne Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) per Mrs. Helen Smith

(Address) 221 S. Broadway

15-

Filed....., 191.....

Registrar.

UC 161923 Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 14 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 25 1923, to August 14 1923, that I saw h— alive on Aug 14 1923, and that death occurred, on the date stated above, at 9P m.

The CAUSE OF DEATH* was as follows:

Sarcoma of the right skull.

(Duration) 2 yrs. 6 mos. da.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. da.

(Signed) Benjamin Watson M. D.

Aug 15, 1923 (Address) 1804 Eutaw pl

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....da. In the State....yrs....mos....da.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Oak Lawn Cem.

DATE OF BURIAL. Aug 17, 1923.

20-UNDERTAKER P. F. Sadowski

ADDRESS 705 S. Ann St

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS ... AGE should be carefully supplied. ... properly classified. Exact statement of OCCUPATION ... important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D78362

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78362

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 E. Madison ST., 11 WARD)

2-FULL NAME Samuel Plumb Barry

(a) RESIDENCE NO. 108 E. Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Chelf

6 DATE OF BIRTH (month, day, and year) Jan. 6, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Salesman

(b) General nature of Industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) Westfield

(State or country) Connecticut

PARENTS

10 NAME OF FATHER John Barry

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know

12 MAIDEN NAME OF MOTHER Helen Plumb

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know

14 Informant Mrs. Susan Barry

(Address) 108 E. Madison Street

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug, 1922, to Aug 16 1923.

that I last saw h-- alive on Aug 13 1923

and that death occurred, on the date stated above, at 1.20 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Oesophagus

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Complete obstruction of Oesophagus (duration) ...yrs. mos. 27 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) John S. Kinlow M. D.

, 19 (Address) 930 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westfield, Connecticut

DATE OF BURIAL 8/17 1923

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

Via Penn. Railroad - Escort - Mrs. Samuel P. Barry

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D78363

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78363

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

City of BALTIMORE: (No. 215 N. High St., 5th Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Libby Forenman

(a) Residence No. 26 N. High St., 5th Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-Single, Married, Widowed, or Divorced, (Write the word.): widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of: Meyer Foreman

6-DATE OF BIRTH (month, day and year): ? ? 1865

7-AGE. 58 yrs. ? mos. ? ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Russia

PARENTS.

10-NAME OF FATHER: Simon Dietz

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Russia

12-MAIDEN NAME OF MOTHER: Ella Koplan

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Russia

14- (Informant) H. N. Disco

(Address) 315 N. Charles St.

15- Filed AUG 16 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH. 8/16/23

16-DATE OF DEATH (month, day and year).

17- I HEREBY CERTIFY, That I attended deceased from July 27, 1923 to Aug 16, 1923

that I last saw her alive on Aug 15, 1923

and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. N. Disco M. D.

8/16, 1923 (Address) 315 N. Charles St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holmes Herring Gun — DATE OF BURIAL: 8/16 1923

20-UNDERTAKER: A. Fineman & Bro — ADDRESS: 1127 E Balto st

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78364

D78364

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1912 Oak Hill ave ST.: 9 WARD)

2-FULL NAME Elizabeth McKean

(a) RESIDENCE. NO. 1912 Oak Hill ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 11 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Robert McKean

6 DATE OF BIRTH (month, day, and year) Sept 16th 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	11	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of Industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER George L Herman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Robert McKean
(Address) 1912 Oak Hill ave

15 Filed AUG 16 1923 H. A. Bell Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15th 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1923, to Aug 15, 1923, that I last saw her alive on Aug 15, 1923, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Chronic interstitial nephritis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Chemistry + clinical

(Signed) Thos McKean M. D.

Aug 16, 1923 (Address) 20 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	Aug 18th 1923
20 UNDERTAKER George J Schilling & Sons	ADDRESS 1120 E Monument St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be properly classified. Exact statement of OCCU- CAUSE OF DEATH in plain terms, so that it may be TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78365

CERTIFICATE OF DEATH.

117 D78365

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital St., No WARD)

2-FULL NAME Alan Pennington Allen

(a) RESIDENCE NO. 3425 Elliott St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lunch Room

(b) General nature of industry, business, or establishment in which employed (or employer) 86

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas E Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Rosie Fink

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Rosie Allen 3425 Elliott St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 14, 1923. to Aug. 14, 1923.

that I last saw him alive on Aug 14, 1923

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

DOW

5 hrs.
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) General peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 3425 Elliott St.

Did an operation precede death? Yes Date of Aug 14, 1923

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) Geo. B Lybert M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Evergreen Cem	Aug 18 1923
20 UNDERTAKER	ADDRESS
H. Sander Sons	1710 Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 6 1923

Spec—12-23-21—E.B.R.S.—400 Bks.

D78366

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001 D78366

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., No Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Samuel Giordano

(a) Residence No. 3703 Eastern Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Single Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1900

7-AGE. 23 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Boiler Maker

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 056

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Italy
(State or Country),

PARENTS.

10-NAME OF FATHER, Joseph Giordano

11-BIRTHPLACE OF FATHER (city or town)..... Italy
(State or Country),

12-MAIDEN NAME OF MOTHER, Gange

13-BIRTHPLACE OF MOTHER (city or town)..... Italy
(State or Country),

14- (Informant) Hospital Record

(Address).....

15- Filed ..... 192.. Registrar.

AUG 16 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/15/23

17- I HEREBY CERTIFY, That I attended deceased from 8/4/23, 19.. to 8/15/23, 19..

that I last saw h. alive on 8/15/23, 19..

and that death occurred, on the date stated above, at 10.29 m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Perforation - Gen Peritonitis Toxemia

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death? ? Laparotomy - Drainage

Did an operation precede death? Yes Date of 8/12/23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) K. W. Galley M. D.

, 19 (Address) Mercy

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Brooklyn	8/17/23
20-UNDERTAKER	ADDRESS
George Ruth	1735 Harford Ave

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78367

165676
D78367

CERTIFICATE OF DEATH.

141

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins Hospital, 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Meekins

(a) RESIDENCE NO. 1709 Latrobe ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16-1882

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	41	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of Industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Vien Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records JOHNS HOPKINS HOSPITAL
(Address)

15 Filed AUG 16 1923, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 11th, 1923, to Aug 14th, 1923.

that I last saw her alive on Aug 14 1923

and that death occurred, on the date stated above, at 7-30 P. m.

The CAUSE OF DEATH* was as follows:

Possibly pulmonary Embolism following operation, for Myomata uteri.

(duration) yrs. mos. 24 hrs.

CONTRIBUTORY (Secondary) Myomata uteri.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of Aug 15, 23

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) R. W. Te Linde, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Cemetery — DATE OF BURIAL Aug 17 1923

20 UNDERTAKER John F. Owens — ADDRESS 538 Dallas

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78368

CERTIFICATE OF DEATH.

90 D78368

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 932 N. Chester St.; 7 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Winifred Raborg

(Residence in Baltimore: No. 932 N. Chester St.; 68 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, June (Month) 15 (Day), 1855 (Year)

7-AGE, 68 yrs. 2 mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 037

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Patrick Gowry

11-BIRTHPLACE OF FATHER (State or Country) Ireland

12-MAIDEN NAME OF MOTHER Honora Ward

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Milton O. Raborg

(Address) 932 N. Chester St

15- Filed ....., 191.....

Robert P. Harrison, Registrar.

Deputy Clerk.

G 161923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH 8—15—23, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from 8—1 191 2 to 8—16 191 23 that I saw h.. alive on 8—16 191 23 and that death occurred, on the date stated above, at 4.20 m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arth. Contra. Deformity

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Rumbley M. D.

8—16, 1923 (Address) 500 Mt. Holly

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Holy Redeemer	Aug. 18, 1923
20-UNDERTAKER Henry Lutz	ADDRESS 1203 N. Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Medical
D78369 4

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78369

CERTIFICATE OF DEATH.

+49

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST., ? WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Wright

(a) RESIDENCE NO. Lancaster S. C. Route #4. ST., WARD Lancaster S. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) ~~WIFE of~~ Thomas Wright (Father),

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cotton Mill.

(b) General nature of Industry, business, or establishment in which employed (or employer) 046

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Missouri Ste.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 16 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15 1923

17 I HEREBY CERTIFY, That I attended deceased from July 22 .1923. to Aug 15 .1923.
that I last saw him alive on Aug 15 .1923.
and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Lymphosarcoma of Mediastinum

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not said Hosp

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Thos. W. Boarding M. D.

9/1. 1923 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lancaster S C — DATE OF BURIAL aug 16 1923

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

AUG 16 1923

THIS CERTIFICATE RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78370

100-00 D78370

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2437 Lakeview Ave. WARD 13)

2-FULL NAME Bettie Kadden

(a) RESIDENCE NO. 2437 Lakeview Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Meyer Kadden

6 DATE OF BIRTH (month, day, and year): May 2nd 1854

7 AGE — Years: 69 — Months: 3 — Days: 14 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Petersburg Va

PARENTS

10 NAME OF FATHER: Isaac Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Henrietta Dreyfus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Etta Kadden (Address): Immediate

15 Filed ....., 19..... Registrar

UG 61923

Robert P. Harrison, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 16th 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 3, 1923, to Aug 16, 1923

that I last saw her alive on Aug 16, 1923

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) ... yrs. ... mos. 13 ds.

CONTRIBUTORY (Secondary): Hypostasis of Urinary Canal

(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam. Symptoms

(Signed) Joseph Sichman, M. D.

Aug 16 1923 (Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship — DATE OF BURIAL: Aug 17th 1923

20 UNDERTAKER: David Sondheim — ADDRESS: 1100 W. Lanvale

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

164910
D78371

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135 V D78371

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Spandauer.

(a) RESIDENCE No. 2322 Madison Ave ST., WARD 11

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Widower

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE of~~ Regie Spandauer

6 DATE OF BIRTH (month, day, and year) - 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 166

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Bernard S

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Sallie Burbaum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed AUG 16 1923, 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1923

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1923, to Aug 16, 1923.

that I last saw him alive on Aug 16, 1923,

and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute retention of urine following benign prostatic Hypertrophy & Pyelonephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyelitis - Pyelonephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unbrown

Did an operation precede death? Yes Date of Aug. 4, 1923

Was there an autopsy? No Laboratory & Clinical

What test confirmed diagnosis?

(Signed) R. R. Harrison, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 8/19/1923

20 UNDERTAKER David Sondheim

ADDRESS 116-20 W. Mt. Royal Ave

mation should be carefully supplied. AGE al... CAUSE OF DEATH in plain terms, so that it m... TION is very important. See instructions on b... Unde... shou... at it may be properly classified. Exact statement of OCCUPA... GE should be stated EXACTLY. PHYSICIANS ... NS THIS PERMANENT RECORD. Every ...

D78372

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78372

CERTIFICATE OF DEATH.

231

1-PLACE OF DEATH

City of BALTIMORE: (No. 1116 Hasselberger St. (23 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Henry Thompson

(Residence in Baltimore: No. 1116 Hasselberger St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

6-DATE OF BIRTH. Unknown (Month) (Day) (Year)

7-AGE. About 43 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer). Odd

9-BIRTHPLACE, (State or Country). Md

PARENTS:

10-NAME OF FATHER. Louis Thompson

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Fannie McCanan

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Thompson

(Address) 1116 Scholl St

15-

Filed AUG 17 1923 192

ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug (Month) 16 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Horton M. D.
Coroner

Aug 16 1923 (Address) Carlton Bldg

*State the Disease Causing Death, or, in Deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death. yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. 707 Auburn St

DATE OF BURIAL. Aug 18 192

20-UNDERTAKER. V. B. Brown & Son

ADDRESS 1088 W. Mont

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78373 — 9v 78373

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 910 Warner ST.; 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Earl Bynum

(Residence in Baltimore: No. # 910 S. Warner St. St.; ... yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	Colored	

6-DATE OF BIRTH, August (Month) 2 (Day) 1921 (Year)

7-AGE, 2 yrs. ... mos. 15 ds. If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Oliver Bynum

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Maggie Brown

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Bynum

(Address) 910 S. Warner St

15- AUG 17 1923 Filed ... 192... ROBERT R. KRAUTER, Registrar of Vital Statistics. Burial Permit ...

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 15 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 11 1923, to Aug 14 1923, that I saw him alive on August 14 1923, and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Meningitis

Convulsions

(Duration) ... yrs. 3 mos. ... ds.

CONTRIBUTORY (Secondary) Measles Duration ... yrs. ... mos. 1 ds.

(Signed) ... M. D.

..., 191... (Address) Hayward Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn St — DATE OF BURIAL, Aug 17, 1923

20-UNDERTAKER, L. V. Brown & Son — ADDRESS 1811 Monroe St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Remarks Probably Whooping Cough

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman,* etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work, and also (*b*) the nature of the business or industry, and, therefore, an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, *first,* the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho pneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor' for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis;* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Broncho pneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septichæmia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (*e. g., sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which give any of the following diseases, without explanation, as the sole cause of death:

Abortion, Cellulitis, Childbirth, Convulsions, Hæmorrhage, Gastritis, Erysipelas, Meningitis, Gangrene, Miscarriage, Necrosis, Peritonitis, Phlebitis, Pyæmia, Septicæmia, Tetanus.

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved); *Suicides, Homicides, Abortions* (*if induced*), whether death is directly or indirectly due to the same.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78374

CERTIFICATE OF DEATH.

90 D78374

1-PLACE OF DEATH

REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 670 Bradley ST.; 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Thomas.

(Residence in Baltimore: No. 670 Bradley St.; 46 yrs., 11 mos. 20 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Fe

4-COLOR OR RACE. Col

5-SINGLE, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~. (Write the word.) W

6-DATE OF BIRTH. Sept (Month) 4 (Day), 1876 (Year)

7-AGE. 46 yrs. 11 mos. 20 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. H. W.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. John Brooke.

11-BIRTHPLACE OF FATHER (State or Country). Md

12-MAIDEN NAME OF MOTHER Ella Cornish.

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence Thomas

(Address) 670 Bradley St.

15- AUG 17 1923 Filed....., 191.... ROBERT R. KRAUTER, BURIAL PERMIT Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug (Month) 14 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2 1923, to Aug 14 1923, that I saw h-r alive on Aug 14 1923, and that death occurred, on the date stated above, at 9-40 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Congestion

(Duration)....yrs....mos. 1 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitat.

(Duration)....yrs....mos....ds.

(Signed) W. W. King M D.

8-16, 1923 (Address) 645 W. Fayette St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Aug 17 1923

20-UNDERTAKER John H Toadvine — ADDRESS 143 Mosher St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78375

CERTIFICATE OF DEATH.

D78375

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 823 Bevan ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geniva Harrison Mc Andrew

(a) RESIDENCE NO. 873 Bevan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed or Divorced (Write word): [redacted]

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 9th 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	22	9	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 070
(c) Name of employer: Home

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: Geo. C. Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Annie Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Annie Harrison
(Address) 811 Leadenhall st

15 Filed AUG 17 1923 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) aforesaid find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Acute Alcoholism
6 hrs
(duration)

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) Geo. B. Horton, M. D.
(Coroner.)
Aug 15, 1923 (Address) Carlton Bldg

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury; and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Aug 17 1923

20 UNDERTAKER: John H. Toadvine — ADDRESS 142 Uniel

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78376 — 129 — D78376

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 Schley Ave ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margarith, Staedtler

(a) RESIDENCE. No. 5 Schley Ave ST., WARD.
(Usual place of abode) (If nonresident, give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr Michael A. Staedtler

6 DATE OF BIRTH (month, day, and year): Aug. 2-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Bltd, md

PARENTS

10 NAME OF FATHER: [redacted] Bremer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Buben

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Michael A Staedtler
(Address) 5 Schley Ave.

15 Filed AUG 17 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 26 1921, to Aug 16 1923

That I last saw her alive on Aug 15 1923

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary): Endocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. L. Zimmerman M. D.

19 (Address) 2858 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1st German United Evan Cem	Aug 18 1923

20 UNDERTAKER: Mrs C. Miller

ADDRESS: 2334 Jefferson St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78377

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 ✓ D78377

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 Bow Alley ST., 18 WARD)

2-FULL NAME Thomas Grant

(a) RESIDENCE NO. 1102 Bow Alley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 27, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	—	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Grant

11 BIRTHPLACE OF FATHER (city or town) Jamaica (State or country) B.W.I.

12 MAIDEN NAME OF MOTHER Emma Aaron

13 BIRTHPLACE OF MOTHER (city or town) Mobile (State or country) Ala

14 Informant Thomas Grant (Address) 1102 Bow Alley

15 Filed AUG 17 1923, 19.... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1923, to Aug 16, 1923, that I last saw h[illegible] alive on Aug 15, 1923, and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Acute Leo Colitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) .....

.....(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. V. Lovell M. D.

8/14, 1923 (Address) 119 Marrowbone Alley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn Cemetery

DATE OF BURIAL August 17 1923

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St

N. B.—MARRIAGE LICENSES, WITH CERTAIN EXCEPTIONS, CANNOT BE ISSUED UNTIL A PHYSICIAN'S CERTIFICATE OF DEATH HAS BEEN FILED WITH THE REGISTRAR. EVERY ITEM OF THIS information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Gorrell.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78378

CERTIFICATE OF DEATH.

94-601 D78378

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1536 N. Caroline ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Gorrell

(a) RESIDENCE NO. 1336 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 94 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state AGE should be carefully supplied. mation should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert B Gorrell

6 DATE OF BIRTH (month, day and year): Sept 15, 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	83	11	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: James Mark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mahalia Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Harry B. Gorrell 1709 N. Broadway

15 Filed AUG 17 1923, 19 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Aug 17 1923

17

I HEREBY CERTIFY, That I attended deceased from aug 17, 1923, to aug 17, 1923, that I last saw h alive on aug 16, 1923, and that death occurred, on the date stated above, at 5.20 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John W Anderson, M. D.

, 19 (Address) 1714 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Aug 20, 23
20 UNDERTAKER: Burkert & Burkert	ADDRESS: 1739 Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78379

CERTIFICATE OF DEATH.

88-003 D78379

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 2417 Woodbrook Ave St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Raymond Lurie

(Residence in Baltimore: No. 2417 Woodbrook ave St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	W	S

6-DATE OF BIRTH. July (Month) 21 (Day) 1914 (Year)

7-AGE. 8 yrs. mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore City Md

PARENTS.

10-NAME OF FATHER. Jacob Lurie

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Rachael Lipman

13-BIRTHPLACE OF MOTHER, (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jacob Lurie

(Address) 2417 Woodbrook Ave

15- Filed AUG 17 1923 ROBERT R. KRAUTH, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. August (Month) 14 (Day) 192.3 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull

(Duration) .....yrs. .....mos. 1 ds.

CONTRIBUTORY (Secondary) Automobile accident

(Duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D. (Coroner.)

August 17 192.3 (Address) 250 Fallsway

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Northern Cemetery DATE OF BURIAL. 8-17 1923

20-UNDERTAKER. Jack Lurie ADDRESS 1439 Eutaw St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78380

CERTIFICATE OF DEATH.

X 60 D78380

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St., WARD)

2-FULL NAME Mrs Hermine Robinson

(a) RESIDENCE NO. Elkridge Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced, (write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lester L. Robinson

6 DATE OF BIRTH (month, day, and year): May 13 1880

7 AGE — Years: 43 — Months: 3 — Days: 2 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Co Md

PARENTS

10 NAME OF FATHER: August Uphoff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christina Schroeder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Lester L. Robinson

(Address): Kenwood Baltimore Co Md

15 Filed AUG 17 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/15/23

17 I HEREBY CERTIFY, That I attended deceased from 8/7/23, 19, to 8/15/23, 19, that I last saw h e alive on 8/15/23, 19, and that death occurred, on the date stated above, at 6.15 p m.

The CAUSE OF DEATH* was as follows:

Thyrotoxicosis.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Elkridge Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) S. W. Crouse, M. D.

(Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Aug 18 1923

20 UNDERTAKER: Jos Soerdens Son — ADDRESS: 217 S. Bond

ROBERT R. KRAUCH
BURIAL PERMIT CLERK

N.B.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Exophthalmic Goiter.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78381

D78381

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1501 N. Madeira ST. 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Naomi Carolyn Bernhardt

(a) RESIDENCE NO. 1501 N. Madeira ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 3 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Thos. W. Bernhardt

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Bertha Wise

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Thos W. Bernhardt
(Address) 1501 N. Madeira St

15 Filed AUG 17 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1923

17

I HEREBY CERTIFY, That I attended deceased from 8-15, 1923, to 8-16, 1923

that I last saw her alive on 8-16 1923,

and that death occurred, on the date stated above, at 11 45 A m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. 1 mos da.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 14 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Dennis Miller, M. D.

, 19 (Address) 1501 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 8/17 1923

20 UNDERTAKER Philip Herrig — ADDRESS 2016 Orleans St

N. B.—WRITE PLAINLY WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

(See affadint over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78382

CERTIFICATE OF DEATH.

4f D78382

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Bank St., V WARD)

2-FULL NAME Dorsey Louis Lee Haywood.

(a) RESIDENCE NO. 1715 Bank ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Lillian A. Haywood

6 DATE OF BIRTH (month, day, and year) May 6 '73

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pilot

(b) General nature of industry, business, or establishment in which employed (or employer) Steamboat

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Louis Haywood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Lillian A. Haywood

(Address) 1715 Bank St

15 Filed ..... 19 ..... ROBERT R. KRAUTER, Registrar

AUG 17 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15 1923 to Aug. 16 1923

that I last saw h alive on Aug. 16 1923

and that death occurred, on the date stated above, at 4 53 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

6

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar J. Goodrich, M. D.

19 (Address) 15 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Elder Hill — DATE OF BURIAL 8/18 1923

20 UNDERTAKER Philip Herring — ADDRESS 2016 Allens

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Personally appeared befre me this 20th day of November 1923. Mrs Lillian Heywood, Wife of L. Dorsey ~~Louis~~ Levi Heywood.
who made affadivit that the name in the Death Certificate #D78382. of Louis L Haywood is incorrect the same should read.
Dorsey ~~Louis~~ Levi ~~Heywood~~ which is the true and correct name.

(Wife)
Seal Lillian Heywood

Seal. George H. Grese
Notary Public

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78383 129 D78383

CERTIFICATE OF DEATH.

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2604 Erdman ave ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Anna Barbara Kohles

(Residence in Baltimore: No. 2604 Erdman Ave St.; 40 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, April (Month) 3 (Day), 1855 (Year)

7-AGE, 68 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER, Matthew Siegner

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Elizabeth Seufert

13-BIRTHPLACE OF MOTHER (State or Country) Germany.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anna M. Collins

(Address) 2604 Erdman

15- Filed AUG 17 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 15 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from January 1923, to Aug 14 1923, that I saw her alive on Aug 14 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pneumonia, Chronic Myocarditis

Asphyxiation, Thrombosis Cerebral

Degeneration

(Duration) 3 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Jacobs M. D.

Aug 15, 1923 (Address) 619 W. Lanvale St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, London Park Cem. DATE OF BURIAL, Aug 17, 1923

20-UNDERTAKER John O. Mitchell ADDRESS 1201 W Fayette

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78384

CERTIFICATE OF DEATH.

161-002 D78384

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman's Hospital, Lafayette & John St., 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Elliott Sayler.

(a) RESIDENCE NO. Woman's Hospital, Lafayette & John ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 15-1923

7 AGE ~~Years~~	~~Months~~	~~Days~~	If LESS than 1 day, 12 hrs. or 30 min.
—	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER John E. D. Sayler

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Illinois

12 MAIDEN NAME OF MOTHER Charlotte Wagner

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Illinois

14 Informant John E. D. Sayler (Address) Woman's Hospital

15 Filed AUG 17 1923 ROBERT P. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15, 1923

17 I HEREBY CERTIFY, That I attended deceased from 5:15 AM Aug. 15, 1923, to 5:45 P.M. Aug. 15, 1923, that I last saw him alive on Aug. 15, 1923, and that death occurred, on the date stated above, at 5:45 P m.

The CAUSE OF DEATH* was as follows:

Birth Injury.
(Mid Forceps Delivery)
(Wt 8 lbs 4 oz Biparietal circum. 11 cms.)
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)
Malposition in utero Breech presentation
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam.

(Signed) G. F. Goff M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shelbyville Ind.	Aug 17 1923

20 UNDERTAKER Wm A Mitchell ADDRESS 1218 W. Fayette

IMPORTANT: WRITE PLAINLY with pen and ink. Use no abbreviations. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78385

CERTIFICATE OF DEATH.

3 D78385

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 213 N pine ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joshua A. William

(a) RESIDENCE NO. 213 N pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel William

6 DATE OF BIRTH (month, day, and year) Dec 23 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer 40

(b) General nature of industry, business, or establishment in which employed (or employer) plasterer

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co.
(State or country)

PARENTS

10 NAME OF FATHER Joshua William

11 BIRTHPLACE OF FATHER (city or town) James Town Co Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) Howard Co.
(State or country)

14 Informant Father Joshua Williams
(Address) 1732 mulberry St

15 Filed AUG 17 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/15/1923

17 I HEREBY CERTIFY, That I attended deceased from 8/13, 1923, to 8/15, 1923,

that I last saw him alive on 8/15, 1923,

and that death occurred, on the date stated above at 6.50 p.m.

The CAUSE OF DEATH* was as follows:

Acute pneumonia

Phthisis.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T. F. Jackson M. D.

, 19 (Address) 1767 N Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL aug 18 1923

20 UNDERTAKER R C Gross 1405 W Baltimore

ADDRESS Eldevy

N. B.—WHITE PAPER, WITH CRIMSON FIBRE THROUGH IT. Every item should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78386

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78386

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. C. 89

City of BALTIMORE: (No. Lafayette Ave & N. Gilmor St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. John P. Brandau

(Residence in Baltimore: No. 2808 Walbrook Ave St.; 43 yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	married

6-DATE OF BIRTH. April 5, 1880 (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
43 yrs. 4 mos. 8 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Founder
(b) General nature of industry, business, or establishment in which employed (or employer) Contractor

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Adam Brandau

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Johanna Schelp

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. C. E. Brandau

(Address) 2808 Walbrook Ave.

15-Filed AUG 17 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 13 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Guiteau M. D. (Coroner.)

Aug. 14 1923. (Address) 2 E Fayette St

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park — DATE OF BURIAL. Aug 17th 1923

20-UNDERTAKER. W. J. Cook — ADDRESS 502 E North

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78387

CERTIFICATE OF DEATH.

D78387

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 800 Guilford Ave 12 WARD)

2-FULL NAME Virginia Jennie Lang

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1800 Guilford St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles H Lang

6 DATE OF BIRTH (month, day, and year): July 14 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	~~July~~	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Jacob Shock

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary Ogden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs H Bowman (Address) 1800 Guilford Ave

15 Filed ..... 19 ..... Registrar

ROBERT R. KRAUTH, Registrar of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 15 1923

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1923, to August 15, 1923, that I last saw h[illegible] alive on August 15, 1923, and that death occurred, on the date stated above, at 6:10 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Arteriosclerosis

Chronic Nephritis

(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Cerebral Hemmhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

(Address) 507 Sheridan Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Aug 17 1923

20 UNDERTAKER: William Cook

ADDRESS: 502 E North Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS STATEMENT RECORDED EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back hack of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78388

HEALTH DEPARTMENT—CITY OF BALTIMORE

8-002

X118 D78388

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., W WARD)

2-FULL NAME Annie Ewing.

(a) RESIDENCE NO. Stevensville Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Olin Ewing

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Jennie Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Oliver Ewing

(Address) Stevensville Md

15 Filed AUG 17 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1923, to Aug 17, 1923, that I last saw her alive on Aug 17, 1923, and that death occurred, on the date stated above, at 9:30 a m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of Aug 15-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) J A Rothrock M. D.

, 19 (Address) Univ. Hospital Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Stevensville Maryland

DATE OF BURIAL Aug 17 1923

20 UNDERTAKER George J. Sands

ADDRESS 153 W Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78389

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-00 D78389

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 E Lombard St., 3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hampden Wright

(a) RESIDENCE NO. 1427 E. Lombard St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Aug 7 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	36	—	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Lumber Dlr

(b) General nature of industry, business, or establishment in which employed (or employer) Edward Cotton

(c) Name of employer Herman Cotton

9 BIRTHPLACE (city or town) (State or country) British West Indies

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) British West Indies

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) British West Indies

14 Informant John R. Jordan

(Address) 1427 E. Lombard St

15 Filed AUG 17 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 14 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 10 1923 to Aug 14 1923, that I last saw him alive on Aug 14 1923 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) Rideal Hamilton, M. D.

, 19 (Address) 1574 Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	Aug 17 1923

20 UNDERTAKER	ADDRESS
Chas. H. Johnson & Co.	847 N. Carlton

N. B.—WRITE PLAINLY, WITH INDELIBLE INK. EACH item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78390

CERTIFICATE OF DEATH.

1 113 D78390

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 615 So. Glover St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas Price

(Residence in Baltimore: No. 615 So Glover St.; yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. Apr 22 1923
(Month) (Day) (Year)

7-AGE. — yrs. 3 mos. 24 ds.

If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. John Price

11-BIRTHPLACE OF FATHER. (State or Country). Md

12-MAIDEN NAME OF MOTHER. Margaret Ezenski

13-BIRTHPLACE OF MOTHER. (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Price

(Address) 615 So Glover St

15- FILED AUG 17 1923 ROBERT R. KRAUTER Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 16 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Infantile Convulsions

Duration ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Premature Birth

Duration ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Kerr M. D.
(Coroner.)

Aug 16 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Accidental

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. St. Stanislaus DATE OF BURIAL. Aug. 17th 1923.

20-UNDERTAKER. M. J. Sadowski ADDRESS 705 S. Amity St

Spec.—1-10-21—M&T—1500 Bks.

D78391 D78391 D78391

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 S. Carey St. ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah L. Huffington

(a) RESIDENCE NO. 4 S. Carey St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. O. Huffington

6 DATE OF BIRTH (month, day, and year) July 12" 1849

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife at home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Peter Emich

11 BIRTHPLACE OF FATHER (city or town) (State or country) U.S.

12 MAIDEN NAME OF MOTHER Harriett Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Harriett E. Ford (Address) 4 S. Carey St.

15 Filed AUG 17 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15" 19 23

17 I HEREBY CERTIFY, That I attended deceased from July 28 . 1923 . to Aug 15 . 1923 . that I last saw her alive on Aug 14 . 1923 . and that death occurred, on the date stated above, at 10 20 a. m.

The CAUSE OF DEATH* was as follows:

Eclampsia.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Carcinoma Liver & Chronic Nephritis. (duration) 2-3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M Burman Hood, M. D.

8/15 19 23 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	Aug 17" 1923
20 UNDERTAKER Jas B. Cook	ADDRESS 1003 N. Bel[illegible]

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78392

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78392

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ford Smith

(a) RESIDENCE NO. 330 E. 21st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70		5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wagon Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co Md (State or country)

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Hospital Records (Address)

15 Filed AUG 17 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug. 8, 1923, to Aug. 16, 1923.

that I last saw h. l. alive on Aug 16, 1923,

and that death occurred, on the date stated above, at 10.40 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug. 14, 1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Thomas Wilson M. D.

, 19 (Address) St. Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Aug 17 1923

20 UNDERTAKER E. A. Weidfield — ADDRESS 501 E 22nd St

N. B.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

165478
D78393

HEALTH DEPARTMENT—CITY OF BALTIMORE

16-60 D78393

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vernon Luers.

(a) RESIDENCE NO. 520 S. Rose St. City. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Rena Luers (mother),

6 DATE OF BIRTH (month, day, and year): June 24, 1922

7 AGE: Years 1 | Months 3 | Days 23. | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: George Luers.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Rena Rosenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: JOHNS HOPKINS HOSPITAL Records

(Address)

15 Filed AUG 17 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923, to Aug 16, 1923, that I last saw him alive on Aug 16, 1923, and that death occurred, on the date stated above, at 11:20 A. m.

The CAUSE OF DEATH* was as follows:

Bacillary dysentery (Flexner)

(duration) yrs. 1 mos da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Stool culture + autopsy

(Signed) Willard C Harrison, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem

DATE OF BURIAL: Aug 17 1923

20 UNDERTAKER: Louis Heeman

ADDRESS: 22 S Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 17 1923

Spec.—1-10-21—M&T—1500 Bks.

D78394

HEALTH DEPARTMENT—CITY OF BALTIMORE

118 D78394

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hospital for the Women of Maryland — REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 1 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Patterson Birch

(a) RESIDENCE No. 1806 St Paul Street ST., ... WARD ..... (Resident)
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 76 yrs. 7 mos. 15 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	Widowed

5a If married, widowed, or divorced (or) WIFE of John D. Birch

6 DATE OF BIRTH (month, day, and year) Jan. 1 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md -

PARENTS

10 NAME OF FATHER Dr. John Hawkins Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md -

12 MAIDEN NAME OF MOTHER Availda Fulford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mary A. Bowling (Address) 1806 St Paul

Filed AUG 7 1923, 19 Robert P. Patterson, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 9, 19 23, to Aug 16, 19 23, that I last saw her alive on Aug 16, 19 23, and that death occurred, on the date stated above, at 5:35 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) ... yrs. ... mos. 3 da.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes - partial —

What test confirmed diagnosis? Autopsy

(Signed) Norman E. Tanenbaum M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL Aug 18 1923

20 UNDERTAKER STEWART & [illegible] — ADDRESS [illegible] NORTH AVE

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78395

CERTIFICATE OF DEATH.

129

D78395

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital-15 St., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Elizabeth Adams

(a) RESIDENCE No. 2106 W North Ave St., 15 WARD (Resident)
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 0 mos. 0 ds. How long in U. S., If of foreign birth? 60 yrs. 9 mos. 2 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Clinton Adams

6 DATE OF BIRTH (month, day, and year) Nov. 14-1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Joseph Armitage

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not-Known

12 MAIDEN NAME OF MOTHER Rebeca Peacock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not-Known

14 Informant Mr Joseph C Adams (Son)
(Address) Washington D.C.

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-16- 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 14th 1923 to Aug. 16th 1923.

that I last saw her alive on Aug. 15th (P.M.) 1923,

and that death occurred, on the date stated above, at 5:00 A. m.

The CAUSE OF DEATH* was as follows: Chronic nephritis. Duration not known. Special form not Known.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of X

Was there an autopsy? no.

What test confirmed diagnosis? Ophthalmoscope & urinalysis.

(Signed) O. H. Hoffman, M. D.

8/16 1923 (Address) 3402 Wallbrook Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Aug/18/1923

20 UNDERTAKER STEWART & MOWEN COMPANY (F. MOWEN, Successor)

ADDRESS 300 W. NORTH AVE.

AUG 7 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC TION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D78396

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78396

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 509 Cumberland St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna D. Hopkins

(a) Residence No. 509 Cumberland St., Ward Frederica Del.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): aug 9 1864

7-AGE: 59 yrs. — mos. 8 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) Camden (State or Country), Delaware

PARENTS.

10-NAME OF FATHER, Ezekiel Dawson

11-BIRTHPLACE OF FATHER (city or town) Camden (State or Country), Delaware

12-MAIDEN NAME OF MOTHER, Sallie Clark

13-BIRTHPLACE OF MOTHER (city or town) Camden (State or Country), Delaware

14- (Informant) William Dawson

(Address) 509 Cumberland St

15- Filed 192 Robert P. Harrison, Registrar. Burial Permit Clerk.

AUG 17 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): Aug 17 1923

17- I HEREBY CERTIFY, That I attended deceased from June 21 1923 to Aug 4 1923

that I last saw h[illegible]er alive on Aug 4 1923

and that death occurred, on ~~the~~ date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

[illegible]a of Uterus and Liver

(Duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? x

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? x

(Signed) Sydney R Miller M. D

19 (Address) 900 St Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fredericka Delaware	Aug 18, 1923
20-UNDERTAKER, George J Smith	ADDRESS 1532 Hollins St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78397

CERTIFICATE OF DEATH.

24 129 D78397

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1506 Riverside ave ST., 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Burns

(a) RESIDENCE NO. 1506 Riverside ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. 11 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Eva L. Burns

6 DATE OF BIRTH (month, day, and year) Sept. 9. 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk, DPW

(b) General nature of industry, business, or establishment in which employed (or employer): Police Dept.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER Patrick Burns

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER Mary Mannion

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Wm. F. Burns

(Address): 1506 Riverside ave

15 AUG 17 1923 . 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 15 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 8 . 1923 . to Aug 15 . 1923.

that I last saw him alive on Aug 12 . 1923.

and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no ...Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) Sidney H. Streett, M. D.

8/16 1923 (Address) 405 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Aug 18 1923
20 UNDERTAKER Margaret A. Flynn	ADDRESS 422 Eight

GE should be stated EXACTLY. PHYSICIANS should be
at it may be properly classified. Exact statement of OCCUPA-
s on back of certificates.

mation should be carefully supplied. AGE s
CAUSE OF DEATH in plain terms, so that it n
TION is very important. See instructions on

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78398

CERTIFICATE OF DEATH.

44 D78398

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1800 Catapsco ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H Hobbins

(a) RESIDENCE NO. 1800 Catapsco ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Hobbins

6 DATE OF BIRTH (month, day, and year) June 1, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York.

PARENTS

10 NAME OF FATHER John Hobbins

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Mary Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs. Mary Hobbins (Address) 1800 Catapsco St.

15 Filed AUG 17 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Aug. 16 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug [illegible], 1923, to Aug 16, 1923

that I last saw [illegible] alive on Aug 16, 1923

and that death occurred, on the date stated above, at 1.30 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Campbell M. D.

1923 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Aug. 18 1923
20 UNDERTAKER	ADDRESS
Margaret L. Flynn	17-21 Light St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78399

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78399

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1751 N. Castle ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond J. Schmitt

(a) RESIDENCE. NO. 1751 N. Castle ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 10 - 1923.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William Schmitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary A. Roulk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant (Address) William Schmitt 1751 N. Castle St

15 [illegible] 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

AUG 17 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17 1923.

17

I HEREBY CERTIFY, That I attended deceased from Aug 10, 1923, to Aug 17, 1923.

that I last saw him alive on Aug 16, 1923.

and that death occurred, on the date stated above, at 1.45 a m.

The CAUSE OF DEATH* was as follows:

Acute Abdominitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Surgery

(Signed) F. Fred Rupricha, M. D.

19 (Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Aug 18 1923
20 UNDERTAKER Lilly and Zeiler	ADDRESS 403 E Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1509 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78400

CERTIFICATE OF DEATH.

1923 D78400

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Tribble (Tribull)

(a) RESIDENCE NO. 804 S. Port ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Tribull

6 DATE OF BIRTH (month, day, and year) Sept. 23-1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	81	10	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Mosser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eva Braun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Mergle

(Address) 804 S. Port St.

15 Filed AUG 17 1923, 19... Robert P. Harrison, Registrar

Special Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1923

17 I HEREBY CERTIFY, That I attended deceased from July 14, 1923, to Aug 15, 1923, that I last saw her alive on Aug 15, 1923, and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Pneumonia

O.K. Conner J. Mowrey

(duration) ... yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Compd. fracture tibia (R.)

(duration) ... yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death? 804 S. Port St.

Did an operation precede death? Yes Date of July 17, 1923

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination

(Signed) Geo. B. Dybert, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Aug 18 1923.
20 UNDERTAKER	ADDRESS
Lilly & Zeile	103 S. Wolfe St.

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78401

CERTIFICATE OF DEATH.

×45 D78401

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 S. Payson ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Weems

(a) RESIDENCE. No. 24 S. Payson ST., WARD. New York City, N.Y.
(Usual place of abode) (If nonresident give city or town and state)

Length of residence in city or town where death occurred [illegible] yrs. 1 mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Octavius T. Weems

6 DATE OF BIRTH (month, day, and year) Mar. 5-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Mann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Jane A. Rudolph

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lebanon, Pa.

14 Informant (Address) Miss Grace Baxter, 24 S. Payson St.

15 Filed AUG 17 1923 Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/16/23

17 I HEREBY CERTIFY, That I attended deceased from Aug 12th, 1923, to Aug 16, 1923, that I last saw h[illegible] alive on Aug 16, 1923, and that death occurred, on the date stated above, at 3:40 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Intestine

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy findings

(Signed) L. Brent Hawks, M. D.

8/16/23 (Address) 1401 Eutaw Pl.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Aug. 18 1923
20 UNDERTAKER	ADDRESS
J. Wm. Offutt, Jr.	220 S. Payson St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D. 78402 HEALTH DEPARTMENT—CITY OF BALTIMORE D. 78402

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hosp. ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie Stevenson

(a) RESIDENCE NO. Colvin St. ST., Low stream ave south WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about ~~75~~ 49			

8 OCCUPATION OF DECEASED —
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) ?
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed 1923 Burial Permit Issued Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 23 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

Probably Pulmonary tuberculosis (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Probably Alcoholism (duration) yrs. mos. ds.

(Signed) W. J. Ruley, M. D. (Coroner)

Aug 20, 192 (Address) 1059 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 192
20 UNDERTAKER Commissioner Health.	ADDRESS

AUG 20 1923

Rev. Wm. E. WOODALL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—6-9-19—H. P. Co.—1000 Bks.

Steckl

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78403

CERTIFICATE OF DEATH.

90 D78403

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 709 N Duncan ST.; 1 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Steckl

(a) RESIDENCE. No. 709 N. Duncan ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Steckl

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Emma Steckl

(Address) 709 N Duncan

15 Filed ..... 19.....

AUG 18 1923

Registrar

Burial Permit Clerk.

ROBERT R. KRAUTER.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-16 1923

17 I HEREBY CERTIFY, That I attended deceased from 8-1 1923 to 8-16 1923

that I last saw h[illegible] alive on 8-15 1923

and that death occurred, on the date stated above, at 1[illegible] m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pending

(Signed) [illegible] M. D.

8-17 1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill	Aug 18 1923
20 UNDERTAKER	ADDRESS
Frank Crockett	1900 Eutaw Place

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78404 X 45 D78404

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1. PLACE OF DEATH Maryland General Hospital
CITY OF BALTIMORE, (No. ..... ST., ... WARD)

2. FULL NAME James Nathan Dean

(a) RESIDENCE NO. Perryman Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred ..... yrs. ..... mos. 30 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	71	-	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Marie M Dean.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ella May

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Mr. Howard Dean Belair Md.

15 Filed AUG 18 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 17 1923

17 I HEREBY CERTIFY, That I attended deceased from July 8 1923 to August 17 1923
that I last saw him alive on August 17 1923
and that death occurred, on the date stated above, at 7 P. m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Caecum

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home
Did an operation precede death? yes Date of July 9-1923
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy & Operation
(Signed) James Hulett Wilkinson M. D.
19 (Address) Md General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lizas Belair Md	Aug 17 1923
20 UNDERTAKER	ADDRESS
De Jos. T Foster	Belair Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78405

CERTIFICATE OF DEATH.

113 D78405

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1217 Ashland Ave. 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... William J. Airey

(a) Residence No. 1217 Ashland Ave. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Child

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6-DATE OF BIRTH (month, day and year) May 31. 1923

7-AGE, ...yrs. 4 mos. 17 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, William B. Airey

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Phila. Penna.

12-MAIDEN NAME OF MOTHER, Catherine Halloran

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md.

14- (Informant) Father Wm. B. Airey

(Address) 1217 Ashland Ave

15- Filed AUG 18 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 17. 1923

17- I HEREBY CERTIFY, That I attended deceased from July 30, 1923, to August 16, 1923, that I last saw him alive on August 16, 1923, and that death occurred, on the date stated above, at 6:00 A. m.

The CAUSE OF DEATH* was as follows:

Diarrhea

Diarrhea & Enteritis

(Duration) ..... yrs. ..... mos. 19 ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed) Frank J. Ayd, M. D.

Aug 17 1923 (Address) 2006 E. Monument St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Redeemer — DATE OF BURIAL, Aug 18, 1923

20-UNDERTAKER, Edward W. Canfield — ADDRESS 924 E. Eager

In order to be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78406

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

37 D78406

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 Gaw ST.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Patterson

(a) RESIDENCE. NO. 1109 Gaw ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Robt. B. Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mrs. Johns 8-17-1923

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs. Helen Patterson

(Address): 1109 Gaw St.

15 Filed AUG 18 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1923, to Aug 13, 1923, that I last saw her alive on Aug 13, 1923, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Robt J. Green, M. D.

(Address) 126 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion

DATE OF BURIAL: Aug 18 1923

20 UNDERTAKER: John W Henderson

ADDRESS 1502 E Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78407

CERTIFICATE OF DEATH.

9 D78407

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 730 Light St.; 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cecil Jackson Howard

(Residence in Baltimore: No. 730 Light St.; ....yrs.,....mos.....da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, May (Month) 1 (Day), 1918 (Year)

7-AGE,	If LESS than 1 day,
....yrs. 3 mos. 16 da.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Chas C Howard

11-BIRTHPLACE OF FATHER (State or Country), Dorchester Co

12-MAIDEN NAME OF MOTHER Elsie Hughes

13-BIRTHPLACE OF MOTHER (State or Country), Dorchester Co

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Cecil C Howard

(Address) 730 Light st

15- AUG 18 1923 ROBERT R. KRAUTER, Burial Permit Registrar.

Aug....., 191....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 17th (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 10th 1923, to Aug 17th 1923, that I saw him alive on Aug 17 1923, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

.....

.....Convulsions

..... (Duration) ....yrs. 3 hours mos.....da.

CONTRIBUTORY (Secondary) Whooping Cough (Duration) ....yrs. 6 weeks mos.....da.

(Signed) J D Holt M. D.

Aug 17, 191... (Address) 715 Light St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL.
Cambridge Md	Aug 18, 1923
20-UNDERTAKER	**ADDRESS**
John F Denny	715 Light St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78408

CERTIFICATE OF DEATH.

D78408

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 104 S. Seventh ST., Brooklyn WARD) 175

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lawrence E Mann

(a) RESIDENCE NO. 104 S. Seventh ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos ... ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M Mann

6 DATE OF BIRTH (month, day, and year) June 3 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Printer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Jacob Mann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't know

12 MAIDEN NAME OF MOTHER Laura J Richet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't know

14 Informant (Address) Mrs Mary M Mann 104 S Seventh St Brooklyn

15 Filed AUG 18 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 12 1923, to Aug 15 1923, that I last saw h[illegible] alive on Aug 15 1923, and that death occurred, on the date stated above, at 3.15 P m.

The CAUSE OF DEATH* was as follows:

Acute Pleurisy

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Heart

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) H Leutkemeyer, M. D.

, 19 (Address) 1340 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Aug 18 1923

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Eating Peaches.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78409

D78409

47

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1109 Ething ST.; 17 WARD)

2-FULL NAME Maggie Parker

(a) RESIDENCE. NO. 1109 Ething ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno Parker.

6 DATE OF BIRTH (month, day, and year) May 19-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada,

PARENTS

10 NAME OF FATHER Isaac Bromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Nutura

12 MAIDEN NAME OF MOTHER Mutura

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Edith E. Giles
(Address) 1109 Ething St

15 Filed ..... 19..... ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 15 1923

17 I HEREBY CERTIFY, That I attended deceased from Fall 1918, to Aug 15, 1923
that I last saw h alive on Aug 14, 1923
and that death occurred, on the date stated above, at 9.50 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast,

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic

(Signed) H. E. Smith M. D.

Aug 15 (Address) Smith Rx Cumberland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Aug 18 1923

20 UNDERTAKER John H. Toadvine ADDRESS Wash St

N. B.—WRITE PLAINLY, WITH USFADING INK—THIS IS A FEDERAL REQUIREMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

165772 D78410

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78410

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST., 5 WARD)

2-FULL NAME Grace Parkinson,

(a) RESIDENCE NO. 146 Colvin St. City ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Catherine Parkinson (mother)

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Thomas —

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: Kath. Parkinson

13 BIRTHPLACE OF MOTHER (city or town) (State or ~~country~~): Balto.

14 Informant (Address): Records. JOHNS HOPKINS HOSPITAL

15 Filed ....., 19 ..... ROBERT R. KRAUER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 16 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1923. to Aug 16 1923.

that I last saw her alive on Aug 16 1923

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

General miliary tuberculosis.

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis.

(duration) 0 yrs. 0 mos. 9 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of —

Was there an autopsy? yes. Post mortem examination of organs.

What test confirmed diagnosis? —

(Signed) William H. F. Wartheu, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem.

DATE OF BURIAL: Aug 20 1923

20 UNDERTAKER: Mrs J. G. Locke

ADDRESS: 1302 Jeffer...

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Body at city morgue. Released by city

D78411

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 227 N Gilmor ST., 19 WARD) 74001 D78411

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jorge Sauerhoff.

(a) RESIDENCE NO. 227 N Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Wht	Don't Know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
45 about			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Paperhanger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Don't Know
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed AUG 18 1923, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 14 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral abscess

Don't Know

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) yrs. mos. ds.

(Signed) [illegible], M. D.
(Coroner.)

8-17, 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 192

20 UNDERTAKER — ADDRESS

AUG 18 1923

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D78412

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78412

CERTIFICATE OF DEATH.

90 H.F. Formed

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 N. Carrollton Av ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Riordan Mrs Grath

(a) RESIDENCE No. 107 N Carrollton Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John. W. Grath

6 DATE OF BIRTH (month, day, and year) Feb 2 - 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
60.	—	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Martinsburg W Va

PARENTS

10 NAME OF FATHER John D. Riordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Johanna Cronan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant John. Mc. Grath, (Address) 107 N Carrollton Ave.

15 AUG 18 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1923, to Aug 17, 1923.

that I last saw her alive on Aug 16, 1923.

and that death occurred, on the date stated above, at 6.50 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Cardiac Weakness.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. D. Driesell, M. D.

, 19 (Address) 211 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 8-20-1923

20 UNDERTAKER H. C. Brauning & Son

ADDRESS 511 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

10-21—M&T—1500 Bks.

D78413

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ D78413

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2714 Mosher ST., 16 WARD)

2-FULL NAME Annie Elizabeth Van Hollen

(a) RESIDENCE NO. 2714 Mosher ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 9 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 21 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	43	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mayfair Record

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Louis H. Van Hollen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary E. McCarty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Phila Pa

14 Informant: Frances M. Van Hollen
(Address): 2714 Mosher St

15 Filed AUG 18 1923 19 ..... Registrar

ROBERT R. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 16, 1923, to Aug 17, 1923, that I last saw h[illegible] alive on Aug 16 & 17, 1923, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. ? mos. ..... da.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

Acute Nurse (duration) yrs. ..... mos. ? da.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Wm. F. Thomas, M. D.

, 19 (Address) 101½ Poplar Grove St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Aug 20 1923
20 UNDERTAKER: Wm. J. Tschudy & Son	ADDRESS: W & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78414 D78414

CERTIFICATE OF DEATH. 3 X 182

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. Curtis Bay Coal Pier 25 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Rajnosk

(Residence in Baltimore: No. on board S.S. Redman St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Unknown

6-DATE OF BIRTH, Unknown
(Month) (Day) (Year)

7-AGE, about 32 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Unknown

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER, (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept,

(Address) Southern Dist

15- AUG 18 1923 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 15th 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm. B. Norton M. D.
(Coroner)

Aug 17 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Accid. Drg

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL. 19

20-UNDERTAKER, ADDRESS

AUG 18 1923

THE MORGUE.

UNIVERSITY OF MARYLAND
ROBERT R. KRAUTER,
Burial Permit Clerk.
0627

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78415 X66 D78415

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1733 Lancaster St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thulesius N. Larsen

(Residence in Baltimore: No. 1733 Lancaster St St.; yrs..... mos..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Unknown

6-DATE OF BIRTH: Unknown (Month) 1..... (Day) (Year)

7-AGE: About 59 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seaman
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Norway

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept.

(Address) Eastern Dist

15-

Filed..... 192.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 15 - 23
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest, and Autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) Thos. B. Horton M. D.
(Coroner.)

Aug 17 1923 (Address) Curtis Bay

*State the Disease Causing Death, Or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, UNIVERSITY OF MARYLAND DATE OF BURIAL, AUG 20 1923 19

20-UNDERTAKER, ADDRESS

AUG 17 1923 Burial Permit Issued

THE MORGUE

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78416 D78416

CERTIFICATE OF DEATH.

162

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 15 WARD)

2-FULL NAME Baby Green

(a) RESIDENCE NO. 1428 Presstman WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Bl.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug-16, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				1 hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore.
(State or country)

PARENTS

10 NAME OF FATHER William Green.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Ida Carer

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant
(Address)

15 Filed AUG 18 1923 ROBERT R. KRAUTER, Registrar
Commissioner Health.
(Burial Permit)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 16, 1923 to Aug 17, 1923.

that I last saw h alive on Aug. 17, 1923.

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) John M. Edmonds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state age should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

57

Spec.—1-10-21 M&T 1500 Bks.

D78417

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D78417

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 13 WARD)

2-FULL NAME Baby Stiffler

(a) RESIDENCE NO. 3403 Cedar ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 14 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Clarence Connelly

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Alabama.

12 MAIDEN NAME OF MOTHER Edna Stiffler

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant .....
(Address)

15 Filed AUG 18 1923 ROBERT R. KRAUTER, Burial Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A LEGAL DOCUMENT. PHYSICIANS should state AGE should be carefully supplied. PHYSICIANS should state mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

251

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 16, 1923.

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....
that I last saw h i alive on Aug 16, 1923, 19 23.
and that death occurred, on the date stated above, at 2.30 P. m.
The CAUSE OF DEATH* was as follows:

Edema neonatorum
Hemorrhage of new born

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? —
(Signed) Elmer Hess, M. D.
, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER Commissioner Health,	ADDRESS

JOHNS HOPKINS HOSPITAL AUG 18 1923

For Wm. F. WOODALL

Spec.—1-10-21—M&T—1500 Blks.

165490
D78418

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X45 D78418

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 7 WARD)

2-FULL NAME Daniel Campbell.

(a) RESIDENCE NO. Bunnlevel, N.C. ST., — WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced
~~HUSBAND of~~
~~(or) WIFE of~~ Gilbert (Brother),

6 DATE OF BIRTH (month, day, and year) — 1859,

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer.

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Wm Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland.

12 MAIDEN NAME OF MOTHER Mary McArthur,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Record, JOHNS HOPKINS HOSPITAL
(Address)

15 Filed AUG 18 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 1923,

17 I HEREBY CERTIFY, That I attended deceased from Aug 2, 1923, to Aug 16, 1923,
that I last saw him alive on Aug 16, 1923,
and that death occurred, on the date stated above, at 1.56 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Transverse Colon followed by Broncho pneumonia

(duration) yrs. 6 mos 7 ds.

CONTRIBUTORY (Secondary) Inanition and Bronchopneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Aug 8, 1923

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. R. Reichert M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dunn N C	Aug 19 1923
20 UNDERTAKER Joseph Abrons	ADDRESS 221 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

See affadinit (over)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78419

D78419

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital. St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William ~~Brooks~~ (Holdbrook)

(a) Residence No. 536 McMeccan St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Black	Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6-DATE OF BIRTH (month, day and year): 1874

7-AGE: 49 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): North Carolina

PARENTS.

10-NAME OF FATHER: John ~~Brooks~~ Holdbrook

11-BIRTHPLACE OF FATHER (city or town) (State or Country): North Carolina

12-MAIDEN NAME OF MOTHER: Louise Peterson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Cortland, Va.

14- (Informant): Municipal Hospital Records

(Address):

15- Filed AUG 18 1923 ROBERT P. KRAUTER, Registrar. Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): August 15, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 19 19 23 to August 15 19 23

that I last saw him alive on August 14 19 23

and that death occurred, on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Myocarditis due to Pneumonia

(Duration) yrs. 5 mos. (history) ds.

CONTRIBUTORY (Secondary): Cardiac Failure

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude S. Breese M. D

8-15-1923 (Address) Municipal Hospital.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	7/18/1923
20-UNDERTAKER	ADDRESS
George T. A. Gibson	513 Lanvale St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Personally appeared before me this 2nd day of August. 1923. J Leon Hall, who made affadavit that the name of Death Certificate # D 78419. is incorrect the same should be William Holdbrook

Seal J Leon Hall

Seal George H Grese

Notary Public

mic interstitial nephritis, etc. The con-
condary or intercurrent) affection need
unless important. Example: *Measles*
sing death), 29 *ds.*; *Bronchopneu-*
ndary), 10 *ds.* Never report mere
terminal conditions, such as "As-
æmia," (merely symptomatic), "At-
lapse," "Coma," "Convulsions," "De-
ngenital," "Senile," etc.), "Dropsy,"
" "Heart Failure," "Hemorrhage,"
"Marasmus," "Old Age," "Shock,"
Weakness," etc., when a definite dis-
ascertained as the cause. Always
iseases resulting from child birth or
as "PUERPERAL *septicemia*," "PUERP-
is," etc. State cause for which sur-
on was undertaken. For VIOLENT
MEANS OF INJURY and qualify as
SUICIDAL, HOMICIDAL, or as *probably*
ossible to determine definitely. Ex-
idental drowning; Struck by railway
t; Revolver wound of head—homi-
d by carbolic acid—probably suicide.
f the injury, as fracture of skull, and
(e. g. *sepsis, tetanus*) may be stated
d of "Contributory." (Recommenda-
ement of cause of death approved by
t Nomenclature of the American Med-
on.)

---

al Space for Further Statements by Physician.

Spec.—1-10-21—M&T—1500 Bks.

D:8420 D:8420 D:8420

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

9

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218-9th St. ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Ruth Mundhenk

(a) RESIDENCE NO. 1218- 9th St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr. 27" 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Chas. Mundhenk

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Virginia L. Miller

13 BIRTHPLACE OF MOTHER (city or town) Balto.

(State or country) Md.

14 Informant C. Mundhenk

(Address) 1218- 9th St.

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17" 19 23

17 I HEREBY CERTIFY, That I attended deceased from Aug 9 , 19 23 . to Aug 17 , 19 23

that I last saw h[illegible] alive on Aug 17 , 19 23

and that death occurred, on the date stated above, at 7.50 A. m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. M. Kieffer, M. D.

8/17/1923 (Address) 2320 Washington Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL Aug 18 1923

20 UNDERTAKER Joseph B. Cook ADDRESS 1063 W. Baltimore St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered. AGE should be carefully supplied. PHYSICIANS should state mation should be stated EXACTLY, so that it may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

165720. D78421

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

78421

159-00278421

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp. ST., 9 WARD)

2-FULL NAME Madeline Brewster.

(a) RESIDENCE NO. 743 Lamont Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of [redacted] WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 2-1923

7 AGE — Years — Months 10 Days. If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Harold

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Della Lair

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed . . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 13 1923 to Aug 17 1923 that I last saw her alive on Aug 17 1923 and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) Life mos. ds.

CONTRIBUTORY (Secondary) Congenital heart disease (patent Ductus Botalli) (duration) yrs. mos. Life ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? X

(Signed) H. H. M'Eech, M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz Cem.

DATE OF BURIAL: Aug. 18 1923

20 UNDERTAKER: Lilly & Zeile.

ADDRESS: 403 S. Wolfe St.

Spec.—1-10-21—M&T—1500 Bks.

78422 D78422

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D78422

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 934 N. Collington Ave ST., 7 WARD)

2-FULL NAME Angela Wolf

(a) RESIDENCE NO. 934 N. Collington Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Sept 13-1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER John Wolf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Francis Noll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Francis Wolf

(Address) 934 N Collington Ave

15 Filed ..... 19 ..... Registrar

Robert P. Harrison,

AUG 19 1923

Asst. Registrar of Vital Statistics.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 17 1923

17 I HEREBY CERTIFY, That I attended deceased from April 28. 1923. to August 17. 1923

that I last saw her alive on August 17. 1923

and that death occurred, on the date stated above, at 10.45 A m.

The CAUSE OF DEATH* was as follows:

Haemorrhage of Lungs

Tuberculosis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Tuberculosis of Lungs (duration) yrs. 4 mos. 17 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Health Department.

(Signed) Dr. W. Kennard, M. D.

(Address) 708 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Aug 20 1923

20 UNDERTAKER: Geo W Fink & Son — ADDRESS: 841 N Wolfe

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. FACTS must be stated EXACTLY. PHYSICIANS should be careful to state mation should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION should be properly classified. Exact statement of OCCUPATION may be CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78423

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78423

CERTIFICATE OF DEATH.

X 7

1-PLACE OF DEATH

REGISTERED NO. 4

CITY OF BALTIMORE: (No. Univ. Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Eleanor Gale

(a) RESIDENCE NO. Chester Ave ST. Annapolis WARD Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 18th 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	8	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis (State or country) Md

PARENTS

10 NAME OF FATHER Hamilton A. Gale

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Alice Loomis

13 BIRTHPLACE OF MOTHER (city or town) Erie (State or country) Pa.

14 Informant Alice Loomis Gale (Address) Annapolis

Filed AUG 19 1923, 19 Robert P. Garrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/18/23 19

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1923, to Aug 18, 1923

that I last saw h e alive on Aug 18, 1923

and that death occurred, on the date stated above, at 12.10 P.m.

The CAUSE OF DEATH* was as follows:

Encephalitis (Septic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) tonsilitis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Annapolis Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) R. J. Plyler, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Md — DATE OF BURIAL Aug 18 1923

20 UNDERTAKER Henry H. Jenkins Sons — ADDRESS McCulloh & Orchard Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78424 D78424

CERTIFICATE OF DEATH. 131

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.....

CITY OF BALTIMORE: (NO. ..... ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathan Rosenstein

(a) RESIDENCE. NO. 3631 Reisterstown ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Whit	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Rosenstein

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Baltimore St

15 Robert P. Harrison, Registrar

Burial Permit Clerk.

AUG 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/17 1923

17

I HEREBY CERTIFY, That I attended deceased from 8/12, 1923, to 8/17, 1923

that I last saw him alive on 8/17, 1923

and that death occurred, on the date stated above, at 10:50 p.m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pyelonephritis & Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Isidore S. Fry, M. D

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	8/19 1923

20 UNDERTAKER ADDRESS

Jack Lewis 1439 E Balt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78425

CERTIFICATE OF DEATH.

58 D78425

REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 905 E. Balto. ST.: 3 WARD)

2-FULL NAME Mrs. Rose Katt.

(a) RESIDENCE. NO. 905 E. Balto ST.. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nathan Katt

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	32	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Laib Katz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Levis 1439 Eutaw street

15 Filed . 19 [illegible] Registrar

UG 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/18 1923

17 I HEREBY CERTIFY, That I attended deceased from 8/2 . 1923 to 8/18 . 1923 that I last saw h e alive on 8/18 . 1923 and that death occurred, on the date stated above, at 4:20 p.m.

The CAUSE OF DEATH* was as follows:

Progressive Pernicious Anemia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Isidore L. Fry M. D.

. 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	8/20/23

20 UNDERTAKER Jack Levis 1434 Eutaw St ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78426

CERTIFICATE OF DEATH.

90 D78426

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1721 Longwood St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hubert Francis Gray

(a) Residence No. 1721 Longwood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Female

4-COLOR OR RACE, White.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 9/16-1907

7-AGE, 14 yrs. 11 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Robt L Gray

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Accomac Co Va

12-MAIDEN NAME OF MOTHER, Flint

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore

14- (Informant) Mrs Margaret E Gray

(Address) 1721 Longwood St

15- Aug 28, 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) August 18/23

17- I HEREBY CERTIFY, That I attended deceased from July 5th, 1923 to August 18, 1923 that I last saw her alive on August 18th, 1923 and that death occurred, on the date stated above, at 3.47 P.M.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis

Nephritis

Natural

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Natural Regurgitation

(Duration) 9 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H C Grant, M. D.

, 19 (Address) 1207 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Aug 28 yrs

20-UNDERTAKER, Gilliam-Cook 5026 Reisterstown

ADDRESS

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Instructions on back of certificates.

G 1923

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78427

CERTIFICATE OF DEATH.

74001 D78427

1-PLACE OF DEATH

City of BALTIMORE: (No. 1610 Bolton St. 14 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George M. Holmes

(Residence in Baltimore: No. 1610 Bolton St.; 12 yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Jan 28 1886 (Month) (Day) (Year)

7-AGE: 37 yrs. 6 mos. 21 ds. If LESS than 1 day, ...hrs. or.... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Trained Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): Professional nursing

9-BIRTHPLACE. (State or Country): Marshall Va

PARENTS.

10-NAME OF FATHER: Washington C. Holmes

11-BIRTHPLACE OF FATHER. (State or Country): Marshall · Va

12-MAIDEN NAME OF MOTHER: Elizabeth A Rund

13-BIRTHPLACE OF MOTHER (State or Country): Marshall · Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Mrs Wm C. Holmes (Brother)

(Address): 1338 A St. S.E. Washington D.C.

15-

Filed ..... 19..... Registrar.

AUG 19 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: August 18 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D. (Coroner)

Aug. 18 1923 (Address) 2802 Edmondson Ave.

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal, or Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Marshall Va	Aug 19 1923

20-UNDERTAKER: John F Lemmy ADDRESS: 715 Light St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78428

CERTIFICATE OF DEATH.

90 D78428

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1623 Druid Hill Ave. St. WARD)

2-FULL NAME Pauline M. Burke

(a) RESIDENCE NO. 1623 Druid Hill Ave. St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Burton Burke

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home work

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Logansboro Penn.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Martha Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

14 Informant Burton Burke

(Address) 1623 Druid Hill Ave.

Filed AUG 7 1923, 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 4th, 1923, to Aug 18th, 1923, that I last saw her alive on Aug 17th, 1923, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 14 da.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis M. D.

, 19 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	Aug 24 1923
20 UNDERTAKER	ADDRESS
E. Alexander	2626 Druid Hill Ave

Burial Permit

INFORMATION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other disease;
~~Except~~ as stated

A. Fr Ellis

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78429

CERTIFICATE OF DEATH.

31 D78429

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2606 Bruce Ter ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary F. Ways.

(a) RESIDENCE. No 2606 Bruce Ter ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of Richard F Ways.
WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 8 - 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	9 Mo.	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Jacob. Kelly

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs Ways
(Address) 2606 Bruce Terrace

15 Filed 19 Robert P. Harrison Registrar

G191923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-18 1923

17

I HEREBY CERTIFY, That I attended deceased from June, 1923, to Aug 18, 1923, that I last saw h[illegible] alive on Aug 17, 1923, and that death occurred, on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis. Lungs & Throat

Chronic. Nephritis

CONTRIBUTORY (Secondary) Chronic Myocarditis (duration) yrs. 2 mos. ds.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. R. C. Kelly M. D.

8/19/23 (Address) 2707 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 20 19 27

20 UNDERTAKER John J. Reilly 1208 W. Fayette ADDRESS

THIS is very important. See instructions on back of certificates. Exact statement ... properly classified.

D78430

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5 129

D78430

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Charles Jones

(Residence in Baltimore: No. 311 Calvin St.; yrs. 60 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE. Col'

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6-DATE OF BIRTH. 1863
(Month) (Day) (Year)

7-AGE. 60 yrs. ..... mos. ..... ds. Undertakers said

If LESS than 1 day, ...hrs. or.... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md'

PARENTS.

10-NAME OF FATHER. Thomas Jones

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Margaett Williams

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence Williams

(Address) 943 Florida Ave. N.W. D.C.

15-

Filed AUG 19 1923 192.....

Robert J. Garrison, Registrar.
Death Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug. 18 1923
(Month) (Day) 192 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Nephritis Chr.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. Straus M. D.
(Coroner)

Aug 19 1923 (Address) 1657 Pine

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Cemetery	Aug 21 19 23
20-UNDERTAKER.	ADDRESS
Joseph F. H. Rochester	1317 Gilmor St.

Spec.—1-10-21—M&T—1500 Blks.

D78431

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 D78431

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 729 McHenry ST., 21 WARD)

2-FULL NAME John F Riley

(a) RESIDENCE NO. 729 McHenry ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhelmina

6 DATE OF BIRTH (month, day, and year) Dec 2 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Bakery

(c) Name of employer —

9 BIRTHPLACE (city or town) ~~Hollumsburg~~ Carlisle Pa
(State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) ~~—~~
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) ~~—~~
(State or country)

14 Informant Mrs. P. Goetz
(Address) 738 McHenry St.

15 Filed ..... 19 ..... Registrar

Robert P. Harrison
Burial Permit Clerk.

G 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/18/1923

17 I HEREBY CERTIFY, That I attended deceased from 8/14/1923, to 8/18/1923, that I last saw h— alive on 8/18/1923, and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thurlow Downin, M. D.

. 19 (Address) 1527 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon P K Cemetery	8/21 1923
20 UNDERTAKER Geo Leimbach & Son	ADDRESS 647 W Pratt St.

N. B.—WHETHER DEATH, WITH OR DURING PREGNANCY, OR ABORTION, THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78432

CERTIFICATE OF DEATH.

57 D78432

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 147 N. Pine St. 20th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles F. Ebardt

(a) RESIDENCE No. 147 N. Pine ST., 20th WARD

(Usual place of abode)

Length of residence in city or town where death occurred lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie C. Ebardt

6 DATE OF BIRTH (month, day, and year) Aug 24th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66.	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of Industry, business, or establishment in which employed (or employer) Proprietor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Raymund Ebardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. R. Ebardt 131 Hillsdale St

15 Filed ..... 19.. Registrar Robert P. Harris Burial Permit Clerk

AUG 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17 1923.

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1920, to August 17, 1923, that I last saw him alive on August 17, 1923, and that death occurred, on the date stated above, at 4.15 A m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation complicating acute bronchitis.

(duration) — yrs. — mos. 5 da.

CONTRIBUTORY (Secondary) Myocarditis complicating diabetes mellitus (duration) Over 3 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Henry C. Ober, M. D.

, 19 (Address) 1203 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Aug 19 23
20 UNDERTAKER	ADDRESS
F. B. Kuppuster	936 Fremont Ave

GENERAL.—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS: Cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78433

CERTIFICATE OF DEATH.

45 D78433

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 647 W. Conway ST., 22 WARD)

2-FULL NAME Catherine Boenner

(a) RESIDENCE NO. 647 W. Conway ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Boenner

6 DATE OF BIRTH (month, day, and year) June 17. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	69	2	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Duties
(b) General nature of Industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS
10 NAME OF FATHER Alexander Leng.
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.
12 MAIDEN NAME OF MOTHER Don't Know.
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Alexandey J. W. Boenner
(Address) 647 W. Conway St

15 Filed ..... 19 .....
Registrar .....

AUG 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 15. 1923 to Aug 17 1923
that I last saw her alive on Aug 16 1923
and that death occurred, on the date stated above, at 1.10 a. m.
The CAUSE OF DEATH* was as follows:

Carcinoma Duodenum

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Age -
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) J. M. D. Engineer M.D.
(Address) 68 Columbia Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem
DATE OF BURIAL Aug 20 1923

20 UNDERTAKER Mr. Mrs. John W. Teufel & Son
ADDRESS 801 N. Fayette

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78434

CERTIFICATE OF DEATH.

113 D78434

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 513 E Preston ST., 10 WARD)

2-FULL NAME Francis H. Parr

(a) RESIDENCE NO. 513 E Preston ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. 1 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Sing'e

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) November 17 - 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER George R. Parr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Anna M. McBride

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mr. George R. Parr

(Address) 513 E. Preston St

15 Filed ... 19 ... Registrar

AUG 19 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from August 4 1923 to August 18 1923

that I last saw him alive on August 18 1923

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis 14

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Hubert R. Meyer M. D.

19 23 (Address) 1031 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Aug. 20 1923
20 UNDERTAKER	ADDRESS
Henry Hosck Son	1301 E Eager St

INK—THIS IS A PERMANENT RECORD. Every ... of information should be stated EXACTLY. PHYSICI... should be ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78435

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 45 D78435

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Howard A. Kelly Hosp.

CITY OF BALTIMORE, (No. 1418 Eutaw Place ST. 14 WARD)

Emelie Steffey

2-FULL NAME Emelie Steffey Wilson

(a) RESIDENCE NO. Cumberland Md. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Homer Wilson

6 DATE OF BIRTH (month, day, and year): Oct - 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore and.

PARENTS

10 NAME OF FATHER: Mc Kendrie Steffey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington D.C.

12 MAIDEN NAME OF MOTHER: Nellie Kilgour

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington D.C.

14 Informant (Address): James Homer Wilson Cumberland Md.

15 Filed AUG 20 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 19 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1923. to Aug 19, 1923.

that I last saw h alive on Aug 19, 1923.

and that death occurred, on the date stated above, at 11.35 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma cæcum

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct 4, 1922

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic tissue

(Signed) Arthur C. Primrose, M. D.

Aug 19 1923 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cumberland Md. DATE OF BURIAL: Aug 20 1923

20 UNDERTAKER: Chas. G. Black ADDRESS: 742 W. North ave

THIS STATISTICAL AND PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78436

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

D78436

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Municipal Hospital ST., 6 WARD)

2-FULL NAME Louisa Johnson

(a) RESIDENCE NO. 228 N. Dallis ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 25 yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records

(Address)

15 Filed AUG 20 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 17, 1923, to Aug 18, 1923, that I last saw her alive on Aug 18, 1923, and that death occurred, on the date stated above, at 11-15 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Infection of Leg.

(duration) ..... yrs. 10 mos. ..... ds.

18 Where was disease contracted if not at place of death? City Home -

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Wm. J. Shelton, M. D.

, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodbury cemetery

DATE OF BURIAL Aug 20 1923

ADDRESS 1631 Orleans

20 UNDERTAKER Edward Bryson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

16 52 31

HEALTH DEPARTMENT—CITY OF BALTIMORE D78437

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hosp ST., 6 WARD)

REGISTERED NO. 113

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Johnson

(a) RESIDENCE No. 1743 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Mch. 8-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Upshur Giles

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Annie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed AUG 20 1923, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 16 19 23

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1923, to Aug 16, 1923, that I last saw h alive on Aug 16, 1923 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) A. H. Wreed M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Burs cemetery — DATE OF BURIAL Aug 20 1923

20 UNDERTAKER Edward Bryan — ADDRESS 1631 orleans

IMPORTANT—THIS STATEMENT RECORD. Every item of information should be carefully supplied. AGE, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78438

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78438 Registered No. C

1-PLACE OF DEATH

City of BALTIMORE: (No. U. P. I. St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thelma Manns

(Residence in Baltimore: No. 1323 Brunt St. St.; yrs., 5 mos. 26 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: female | 4-COLOR OR RACE: colored | 5-Single, Married, Widowed, or Divorced. (Write the word.): single

6-DATE OF BIRTH: Feb. 20 1923 (Month) (Day) (Year)

7-AGE: yrs. 5 mos. 26 ds. | If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Jacob Hooper

11-BIRTHPLACE OF FATHER, (State or Country): Md

12-MAIDEN NAME OF MOTHER: Elvira Manns

13-BIRTHPLACE OF MOTHER, (State or Country): Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elvira Manns

(Address) 1323 Brunt St

15-

Filed AUG 20 1923 19

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 18 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(Duration) yrs. mos. 1 ds.

(Signed) D. F. Hennessy M. D.
(Coroner)

Aug. 18 1923 (Address) 2802 Eastern Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt Auburn | DATE OF BURIAL: 8-20-, 1923

20-UNDERTAKER: Daniel Easton | ADDRESS 916 Ea ne

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78439

CERTIFICATE OF DEATH.

129 D78439

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 698 Pine ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Jackson

(a) RESIDENCE NO. 698 Pine ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	46.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 0/0

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant E. R. Stewart

(Address) 678 Pine St

15 Filed AUG 20 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1923

17

I HEREBY CERTIFY, That I attended deceased from May 5th, 1923, to Aug 18th, 1923, that I last saw h[illegible] alive on Aug 18th, 1923, and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows: (a) Carcinoma Sympinis Nephritis

(duration) 4 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) Medical yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Symptoms, Microscopic

(Signed) [illegible], M. D.

, 19 (Address) 607 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 8-20 1923

20 UNDERTAKER: David Easton

ADDRESS: [illegible]

IMPORTANT.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] CERTIFICATE is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Uremic Nephritis

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78440

CERTIFICATE OF DEATH.

153 D78440

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. 3 WARD)

2-FULL NAME Lewis Rose

(a) RESIDENCE NO. 106 ~~Dollar~~ S. Dallas St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Nick Rose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Municipal Hospital Records

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 17 19 23

17

I HEREBY CERTIFY, That I attended deceased from June 25, 1923, to August 17, 19 23

that I last saw him alive on August 17, 19 23

and that death occurred, on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH* was as follows:

Osteomyelitis

(duration) 1 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 17, 23

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) Wm. J Fullon, M. D.

8-18 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Aug 20 1923
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 ~~7~~ Eutaw St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*. or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not Laboratory

D78441

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X196D78441

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Curtis Bay Copper & Iron Works St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Heinr C. Heim

(Residence in Baltimore: No. The Anchorage, Foot of Broadway St.; yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Unknown

(Month) (Day) (Year)

7-AGE. About 25 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Seaman
(b) General nature of Industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Norway

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Norway

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Norway

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Eastern Dist

15- Filed AUG 20 1923 192.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 16 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or Inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally Electrocuted

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. B. Gordon M. D.
(Coroner)

Aug 19 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Bal to. Md

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Trinity Cemetery

DATE OF BURIAL. Aug 20 1923

20-UNDERTAKER. George J Ruth

ADDRESS 1735 Harford

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78442

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78442

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1106 E. Boulden St. ST. No WARD)

2-FULL NAME Bridget Cooney

(a) RESIDENCE. NO. 1106 E. Boulden ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Cooney.

6 DATE OF BIRTH (month, day, and year) Feb 8- 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Thomas Kennedy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Bridget Newell.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Lawrence Cooney.

(Address) 3133 Dillon St.

15 Filed AUG 20 1923, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 17 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1923, to Aug 17, 1923, that I last saw h[illegible] alive on Aug 16, 1923, and that death occurred, on the date stated above, at 2.10 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastases abdominal organs

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 1922

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B. Tilghman M. D.

8/17. 1923 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	Aug 20 1923
20 UNDERTAKER	ADDRESS
Lilly & Feiler	403 S. Wolfe St

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. • Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78443

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-002

D78443

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 S. Rabinson ST., 1 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Warran Garner

(a) RESIDENCE No. 305 S. Rabinson ST. 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Baby

6 DATE OF BIRTH (month, day, and year) May 26 1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas A Garner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elsie Gruppe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Thomas A Garner

(Address) 305 S. Rabinson

15 Filed , 19 Registrar

AUG 20 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to Aug 18, 1923

that I last saw ~~him~~ alive on Aug 18, 1923

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Open Foreamen Ovale

(duration) yrs. 2 mos 23 ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Fitlow M. D.

8/19, 1923 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	Aug 20 1923

20 UNDERTAKER Johannah Carolan ADDRESS 1004 Biguil St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

078444

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 078444

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 3611 Liberty Hghts ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Elizabeth Skinner

(a) RESIDENCE No. 3611 Liberty Hghts ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6y yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fred L Skinner

6 DATE OF BIRTH (month, day, and year): Apr 3 1855

7 AGE — Years: 68 Months: 4 Days: 15 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Geo Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary V Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs Florence Skinner

(Address): 3611 Liberty Hghts

15 Filed AUG 20 1923 19 G G Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1923, to Aug 18, 1923, that I last saw h alive on Aug 18, 1923, and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of mediastinal Glands

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) John A Evans M. D.

, 1923 (Address) 101 N Eutaw.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Mount — DATE OF BURIAL: Aug 20 1923

20 UNDERTAKER: H P Tudor & Son — ADDRESS: Howard St

IMPORTANT; WRITE PLAINLY, WITH PENCIL OR INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D78445

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78445

162

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 27 WARD)

2-FULL NAME ~~Baby Hammett~~ Geo. Anthony Hammett

(a) RESIDENCE NO. 44 01 Ready Ave. ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) August 13/23

7 AGE — Years — Months — Days 5 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore MD
(State or country)

PARENTS

10 NAME OF FATHER Raymond Hammett

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) MD

12 MAIDEN NAME OF MOTHER Fozia Hennelly

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) N. C.

14 Informant W. W. Gray

(Address) Johns Hopkins Hospital

15 Filed AUG 20 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1923

17 I HEREBY CERTIFY, That I attended deceased from August 13, 1923, to Aug 18, 1923,

that I last saw him alive on Aug 18, 1923,

and that death occurred, on the date stated above, at 5 30 a. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of the brain

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? — Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. W. Gray, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Aug 20 1923

20 UNDERTAKER: W. J. Sudendorf — ADDRESS: Norbury

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

KODAK S·A

165748
Spec.—1-10-21—M&T—1500 Rbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78446 D78446

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Doris M. Bear

(a) RESIDENCE No. 109 N. Ellwood Ave ST. Lanty WARD
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 22 1922

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	9	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS
10 NAME OF FATHER Thomas Berry
11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto
12 MAIDEN NAME OF MOTHER Hulda Gartner
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant (Address) Johns Hopkins Hospital Deeds

15 Filed AUG 20 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1923, to Aug. 18, 1923, that I last saw her alive on Aug 18, 1923, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)
(duration) 0 yrs. 0 mos 10 ds.
CONTRIBUTORY (Secondary) Acute otitis media
(duration) 0 yrs. 0 mos. 3 ds.

18 Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of —
Was there an autopsy? Yes. Post mortem examination
What test confirmed diagnosis?
(Signed) William H. F. Wartten M. D.
, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel — DATE OF BURIAL: Aug 20 1923

20 UNDERTAKER Henry Lutz — ADDRESS 1203 N. Broadway

Spec.—1-10-21—M&T—1500 Bks.

D78447

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

122 D78447

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1033 N Broadway ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Dorathy Plitt

(a) RESIDENCE No. 1033 N Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 13 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER George Plitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary F. Sherer

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Frances Plitt

(Address) 1033 N. Broadway

15 Filed AUG 20 1923 [signature], Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17 1923

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1923, to Aug 17, 1923, that I last saw her alive on Aug 16, 1923, and that death occurred, on the date stated above, at 10 [illegible] a.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Dilatation of Heart

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A L Gunstream, M. D.

Aug 18 1923 (Address) 2013 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	8 20 23
20 UNDERTAKER H. E. Hughes	ADDRESS
424 N. Broadway	

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No alcoholic

Spec—12-23-21—E.B.R.S.—400 Bks.

D78448 HEALTH DEPARTMENT—CITY OF BALTIMORE D78448

CERTIFICATE OF DEATH. 31

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No.....St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Municipal Tuberculosis Hospital

2-FULL NAME Dora Moore

(a) Residence No. 1402 Riggs ave. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1890

7-AGE.	If LESS than 1 day,
33 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Thomas Moore

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12-MAIDEN NAME OF MOTHER, Mary Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14- (Informant) Hospital Records

(Address) M.T.H.

15- Filed 19 Registrar.

AUG 20 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 17, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 25, 19 23, to Aug. 17, 19 23,

that I last saw her alive on Aug. 17, 19 23,

and that death occurred, on the date stated above, at 1.15 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous enteritis

(Duration) yrs. 2 mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? T. B. in sputum, X-ray

(Signed) L. A. Lallaf M. D

8-17-23 (Address) Municipal Tbc. Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Maryland Memorial Park | DATE OF BURIAL. Aug 20, 1923

20-UNDERTAKER James H. Dennis | ADDRESS 1343 Greenmount St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78449

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D78449

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1330 h. mount ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Celie Prettyman

(a) RESIDENCE. No. 1330 h. mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lloyd Prettyman

6 DATE OF BIRTH (month, day, and year) May 2, 1876

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince George Co. Maryland

PARENTS

10 NAME OF FATHER Logan Green

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince Geo. Co. Maryland

12 MAIDEN NAME OF MOTHER Jane Glascow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prince Geo. Co. Maryland

14 Informant Lloyd Prettyman (Address) 1330 h. mount st

15 Filed ..... 19 ..... Registrar

AUG 20 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17, 1923

17 I HEREBY CERTIFY, That I attended deceased from 8-5-, 1923, to 8-17-, 1923 that I last saw h. alive on 8-17-, 1923 and that death occurred, on the date stated above, at 1.50 p.m.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic valvular disease of heart

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs & symptoms

(Signed) John E. I. Compres M. D.

, 19 (Address) 1405 h. mount.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Aug 20
20 UNDERTAKER Samuel Hemsley	ADDRESS 1600

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

D78450

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78450

CERTIFICATE OF DEATH.

3M

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 32 E. Gilmore St., 27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret E. Meyer

(Residence in Baltimore: No. 32 E. Gilmore ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	White	Married

6-DATE OF BIRTH. Oct (Month) 19 (Day) 892 (Year)

7-AGE. 30 yrs. 9 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. George C. Krach

11-BIRTHPLACE OF FATHER, (State or Country). Maryland

12-MAIDEN NAME OF MOTHER. Pauline Neubauer

13-BIRTHPLACE OF MOTHER, (State or Country) Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Meyer

(Address) 32 E Gilmore ave. Hamilton

15- AUG 20 1923 Filed ..... 192.. (.....) Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 17 (Day) 923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D. (Coroner.)

1923 (Address) 3632 Roland ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Jerusalem Cemetery	Aug. 20 1923
20-UNDERTAKER.	ADDRESS
Fred'k Lasselmann Sons	Fulton and

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D78451 HEALTH DEPARTMENT—CITY OF BALTIMORE D78451

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (E. Hamilton Ave. near Radecke ave. ST., 90 WARD)

REGISTERED NO. 90 Roseberg.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2-FULL NAME Joseph Ritter

(a) RESIDENCE E. Hamilton Ave. near Radecke ave, ST., 26 WARD Roseberg

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Ritter

6 DATE OF BIRTH (month, day, and year) May 6th 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired Truck Farmer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown Hungary

PARENTS

10 NAME OF FATHER Gabriel Ritter

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Hungary

12 MAIDEN NAME OF MOTHER Anna Myrsee

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Hungary

14 Informant Joseph Ritter (Address) Roseberg Md.

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 17th 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug. 10, 1923 to Aug 17, 1923

that I last saw him alive on Aug. 16th, 1923

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis (Mitral Insufficiency) ? long duration (duration) ? yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No but some enlarged ing. glands were removed for study.

What test confirmed diagnosis?

(Signed) A. L. Williamson M. D.

8/17, 1923 (Address) 13 Bel Air Rd., Roseberg, Balto. Co. Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Aug 20 1923
20 UNDERTAKER	ADDRESS
Fred Lossenhorse	Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... DATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

"Campbell"

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78452

CERTIFICATE OF DEATH.

1923 D78452

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1140 Riverside Ave (Street) 24th (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer E. Lowry

(a) RESIDENCE NO. 1140 Riverside Ave (Street) 24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 16 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Alfred Lowry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Bertha Simpkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Alfred Lowry

(Address) 1140 Riverside Ave.

15 Filed AUG 20 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1923, to Aug 18, 1923

that I last saw h alive on Aug 18, 1923

and that death occurred, on the date stated above, at 6-10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(duration) ... yrs. mos 10 da.

CONTRIBUTORY (Secondary) Exhaustion (duration) ... yrs. mos. ... 2 da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

Signed R. H. Campbell M. D.

1923 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Eastern Ave | DATE OF BURIAL: 8/20 1923

20 UNDERTAKER: J. Edgar Woods | ADDRESS: 1317 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78453 D78453

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2031 N. Fulton Ave ST., 15 WARD)

2-FULL NAME Henrietta Glanville

(a) RESIDENCE No. 2031 N. Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a ~~M married~~, widowed, ~~or divorced~~

~~HUSBAND of~~ (or) ~~WIFE~~ of Charles M. R. Glanville Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md. Balto.

PARENTS

10 NAME OF FATHER John Holman

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Harry Glanville (Son)

(Address) 2031 N. Fulton ave.

15 Filed AUG 20 1923 H. Lann Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19" 1923

17 I HEREBY CERTIFY, That I attended deceased from Febyst, 1923, to Aug 19, 1923, that I last saw her alive on Aug 19, 1923 and that death occurred, on the date stated above, at 11.40 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

Ataxi (duration) 7 yrs. mos. ds.

Mitral Regurgitation

CONTRIBUTORY (Secondary) (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) O. N. Duvall, M. D.

8/19 1923 (Address) 1817 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug 22 1923
20 UNDERTAKER Weldon W. Harris	ADDRESS 1018 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D78454

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78454

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 465-E. Lanvale ST., 17 WARD)

2-FULL NAME William H. Page

(a) RESIDENCE NO. 413-E-Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	~~Single~~ Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 11-1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Rigger
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. Page
(Address) 410-E. Lanvale

15 Filed AUG 20 1923 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/18 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Adv. Ass. Heart

Died Suddenly (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) W. J. Riley, Coroner. M. D.

Aug 19, 1923 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Aug 21 1923

20 UNDERTAKER	ADDRESS
H. C. Wieda	914 Fremont Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D78455

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78455

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. York Road & Lakeside Av WARD 7)

2-FULL NAME Agnes T. O'Neill

(a) RESIDENCE NO. York Road & Lakeside WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 31-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Owen O'Neill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret McGrath

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Was. D. C

14 Informant Estelle Logan

(Address) York Road & Stageside

Filed AUG 20 1923

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 2 1922 to Aug. 18 1923, that I last saw her alive on Aug. 18 1923, and that death occurred, on the date stated above, at 11.20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. D. Koons M. D.

8-9 1923 (Address) 5600 York Rd. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Aug 21	1923
20 UNDERTAKER	ADDRESS
H. C. Windefeld	914 Greenmt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78456

CERTIFICATE OF DEATH.

90 D78456

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 412 E. 21st. St. ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mattie L. Hammett

(a) RESIDENCE No. 412 E. 21st. St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James R. Hammett

6 DATE OF BIRTH (month, day, and year) Oct. 11, 1849

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jetson L. Gill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Desdemonia Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Daisey E. Blake

(Address) 412 E. 21st. St.

15 Filed AUG-20 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18 1923

17 I HEREBY CERTIFY, That I attended deceased from , 1920, to August 18, 1923.

that I last saw her alive on August 18, 1923

and that death occurred, on the date stated above, at 10.10 P m.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

(duration) Indefinite mos ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

8/25, 1923 (Address) 2430 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hampstead Md.

DATE OF BURIAL: Aug. 21, 1923

20 UNDERTAKER: Wm. C. Black,

ADDRESS: 927 N. Broadway,

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78457

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 D78457

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., No WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Redmer Redner

(a) RESIDENCE NO. Bay View Hospital ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph Redmer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Municipal Hospital Records, (Address)

15 Filed AUG 20 1923 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18 19 23

17

I HEREBY CERTIFY, That I attended deceased from August 8, 19 23, to August 18, 19 23, that I last saw him alive on August 18, 19 23, and that death occurred, on the date stated above, at 4:55 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis (history - 20 yrs.)
Chronic myocarditis
Myocardial insufficiency

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude S. Bruce M. D.

8-20 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Aug. 20 1923
20 UNDERTAKER	ADDRESS
Wm. E. Black	922 N. Broadway

D 78458 HEALTH DEPARTMENT—CITY OF BALTIMORE 182

D 78458

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Foot Cross St St., 24 Ward)

Registered No. D 78458

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown

(Residence in Baltimore: No. Unknown St.; yrs. ..... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Unknown

6-DATE OF BIRTH: ..... Unknown ..... 1..... (Month) (Day) (Year)

7-AGE: about 35 yrs. ..... mos. ..... ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Unknown
(b) General nature of industry, business, or establishment in which employed (or employer): 087

9-BIRTHPLACE, (State or Country): Unknown

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Police Dept

(Address) Southern Dist

15-

Filed ..... 192 .....

Registrar.

AUG 21 1923

THE MORGUE

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 16 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by Inquest, and (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Drowning

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B. Horton M. D. (Coroner.)

Aug 17 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL: PUBLIC CEMETERY.

DATE OF BURIAL: 19

20-UNDERTAKER: Commissioner Health,

ADDRESS

AUG 21 1923

Spec.—1-10-21—M&T—1500 Bks.

D78459

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D78459

REGISTERED NO.

1-PLACE OF DEATH 3099 N. Robinson St 6

CITY OF BALTIMORE: (NO. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Rhea Slayoman

(a) RESIDENCE NO. 3099 N. Robinson ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 15 mos. ds. How long in U. S., if of foreign birth? yrs. 15 mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	15		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph A. Slayoman

11 BIRTHPLACE OF FATHER (city or town) Balto., Md.
(State or country)

12 MAIDEN NAME OF MOTHER Helen L. Schempp

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Mother.
(Address)

15 Filed AUG 20 1923 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 11, 1923, to Aug. 18, 1923, that I last saw her alive on Aug. 18, 1923, and that death occurred, on the date stated above, at 5.20 A. m.

The CAUSE OF DEATH* was as follows:

Pleo-colitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. C. Sobiral, M. D.

, 19 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dew Cathedral Cemetery

DATE OF BURIAL 8/2/1923

20 UNDERTAKER E. D. Fanning & Son

ADDRESS 938 E. Lafayette Ave

Spec—12-23-21—E.B.R.S.—400 Blks.

D78460 HEALTH DEPARTMENT—CITY OF BALTIMORE D78460

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2650 Frederick Ave. St., 20 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Kelly

(a) Residence No. 2650 Frederick Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Dec. 7-1921

7-AGE, 1 yrs. 8 mos. 16 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Edw. Kelly

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md

12-MAIDEN NAME OF MOTHER, Lillian Barrett

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Edw. Kelly

(Address) 2650 Frederick Ave

15- AUG 20 1923 Filed, 192 G Y Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug. 18, 1923

17- I HEREBY CERTIFY, That I attended deceased from Augsut 17 19 23 August 18 19 23

that I last saw h. alive on " " 19 23

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Intoxication

(Duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Convulsions -- Acidosis

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of "

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw V Cookman M. D.

8/20 19 23 (Address) 24 N. Fulton Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL, Aug 20 19 23

20-UNDERTAKER Margaret E Flynn — ADDRESS 1422 Eutaw Pl

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78461 ✓ D78461

CERTIFICATE OF DEATH.

179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 So Bouldin ST., 16 WARD)

2-FULL NAME Edna Curry

(a) RESIDENCE NO. 120 So. Bouldin ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	75	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER Robert Curry

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) England

12 MAIDEN NAME OF MOTHER Ada Hinkleman

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Balto

14 Informant Robert Curry
(Address) 120 So Bouldin

15 Filed ..... 19..... Registrar

UG 20 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 8, 1923, to Aug 20, 1923,

that I last saw her alive on Aug 20, 1923,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Burns — Fire

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Shock

(duratinn) yrs. mos. 12 ds.

Where was disease contracted if not at place nf death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test cnnfirmed diagnosis? .....

(Signed) Jas Schenck, M. D.

19 (Address) 3307 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL Aug 21 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E Fayette

CORONER FOR BALTIMORE CITY-EASTERN DIST.

Robert P. Garrison, Deputy Permit Clerk

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accident - Clothes
caught fire from
lighted candle

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78462

D78462

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Ristertown Rd + Amus ave. ST., 28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gladys E. Gill

(a) RESIDENCE NO. Ristertown Rd + Amus ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carl Gill

6 DATE OF BIRTH (month, day, and year) Sept. 5, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	22	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Nutta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Jane Potts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Hospital Records

(Address) Edgewood Farm

15 Filed AUG 20 1923, 19 Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19 1923

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1923, to Aug 16, 1923, that I last saw her alive on Aug. 19, 1923, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. A. Bridges, M. D.

19 (Address) Edgewood, Towson, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dorsey Ridge	Aug 21 1923
UNDERTAKER	ADDRESS
Harry A. Fitzke	1534 W Lombard

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-25—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

× 110 D78463

D78463

REGISTERED NO.....

1-PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. University Hospital ST., 4 WARD)

2-FULL NAME Mrs Nellie Reynolds -

(a) RESIDENCE NO. Ourse Mills Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 8 ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-4-1875

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
48	4	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Md

PARENTS

10 NAME OF FATHER Geo Dawson

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Byus

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Wm F Reynolds
(Address) Ourse Mills

AUG 20 1923 Filed ..... 192 ..... Registrar
Burial Permit Clerk.

Robert P. Harrison,

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Perforation of Stomach

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Svallow of Pin Stick

(duration) ... yrs. ... mos. 2 ds.

(Signed) ..... M. D.
(Coroner.)
..... 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., 8 ds. In the State ... yrs. life ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence Owings Mills Md.

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sykesville Md.	Aug 22 1923

UNDERTAKER Jas. R. Steer

ADDRESS Sykesville Md.

AGE should be carefully supplied. ... of infant
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec–12-23-21–E.B.R.S.–400 Bks.

D78464 HEALTH DEPARTMENT—CITY OF BALTIMORE D78464

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

City of BALTIMORE (No. 1124 Mauntcoke St., 21 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles J. Flowers

(a) Residence No. 1124 Mauntcoke St., 21 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of [illegible] Mary Flowers

6-DATE OF BIRTH (month, day and year) June 9 1855

7-AGE. 68 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Woodworker

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town and State or Country). New York

PARENTS.

10-NAME OF FATHER, Chas J Flowers

11-BIRTHPLACE OF FATHER (city or town and State or Country). Maryland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town and State or Country), Germany

14- (Informant) Mary Flowers

(Address) 1124 Mauntcoke

15-

Filed ..... 192..... Registrar.

AUG 21 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 19 1923

17- I HEREBY CERTIFY, That I attended deceased from June 21 1923 to Aug 19 1923

that I last saw him alive on Aug 19 1923

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(Duration) 1 yrs. mos. ds.

18-Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) John G Clemmens M. D.

19 (Address) 1126 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. London Park Cemetery

DATE OF BURIAL, 8/22 1923

20-UNDERTAKER. Geo Lembert & Son

ADDRESS 647 W Pratt St

N. B.—WHITE CARDS, WITH CHARCOAL PAPER BACKING, FOR ONE COPY. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78465

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78465

CERTIFICATE OF DEATH.

74-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1112 N. Eutaw Place St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Margaret R. Gold

(Residence in Baltimore: No. 1112 N. Eutaw Place St.; 12 yrs., ... mos. ..... ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
female	white	Single

6-DATE OF BIRTH. about ..... (Month) ..... (Day) 1862 (Year)

7-AGE.	If LESS than 1 day,
61 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... None .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE. (State or Country). Va.

PARENTS.

10-NAME OF FATHER. Wm. H. Gold

11-BIRTHPLACE OF FATHER. (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Miss Woodell

13-BIRTHPLACE OF MOTHER. (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. L. Carter

(Address) 2900 N. Calvert St

15-

Filed ..... 192.....

Registrar.

Robert P. Garrison,
Chief Permit Clerk.

AUG 20 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 19 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(Duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary) no history.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Hennessy M. D.
(Coroner.)

Aug. 20 1923 (Address) 2202 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Manchester Va	Aug 21st 1923

20-UNDERTAKER. Joseph B. Cook ADDRESS 1003 N. Bath St

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78466 D78466

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE. (No. Jno Hopkins Hospital St. 5 Ward)

2-FULL NAME. Julia Burns

(Residence in Baltimore: No. 424 N. Central ave St.; yrs. mos. ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Single

6-DATE OF BIRTH, June (Month) 2 (Day) 2nd 1923 (Year)

7-AGE, yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None.
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Harry Burns

11-BIRTHPLACE OF FATHER, (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Martha Nicholas

13-BIRTHPLACE OF MOTHER, (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harry Burns
(Address) 424 N Central ave

15-
Filed ..... 192.....
Registrar.

AUG 20 1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 17 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Marasmus.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)
1923 (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Hondcidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.
Asbury Cemetery aug. 21st 1923

20-UNDERTAKER. ADDRESS
Milton Davis 315 N Eden st

Spec.—1-10-21—M&T—1500 Bks.

Price

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78467

D78467

CERTIFICATE OF DEATH. ✓

89

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2776 W. North Ave. WARD)

2-FULL NAME Eva Price

(a) RESIDENCE NO. 2776 W North Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life time mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Price

6 DATE OF BIRTH (month, day, and year): April 1st 1852

7 AGE: Years 71 | Months 4 | Days 18 | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Price

(Address): 2776 W North Ave

15 Filed ..., 19 ... Registrar

AUG 20 1923

Robert P. Garrison, Local Health Officer.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 19 th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1920 to Aug. 19 1923

that I last saw her alive on Aug. 19, 1923

and that death occurred, on the date stated above, at 12 30 a.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) 5- yrs.? mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Joseph William Kelly M. D.

, 19 (Address) 910 Brooks Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship. DATE OF BURIAL: Aug 21 1923

20 UNDERTAKER: L. Wand Sondheim ADDRESS: 1-19 W. Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78468

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78468

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Homeland Ave. ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Neuman I. Gusdorff

(a) RESIDENCE NO. Homeland Ave ST., ... WARD ...

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Gusdorff

6 DATE OF BIRTH (month, day, and year) May 17, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture

(b) General nature of industry, business, or establishment in which employed (or employer) Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Isaac A. Gusdorff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Celia Lotz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. I. A. Gusdorff (Address) Homeland Ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/20/1923

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1923, to Aug 20, 1923, that I last saw h- alive on Aug 23 1923, and that death occurred, on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Streptococcus viridens septicemia

(duration) ... yrs. 4 mos ... ds.

CONTRIBUTORY (Secondary) Embolism

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Leitz, M. D.

8/20, 1923 (Address) 2040 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oheb Shalom Assn.	8/23/1923
20 UNDERTAKER	ADDRESS
David Sondheim	118-20 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78469 HEALTH DEPARTMENT—CITY OF BALTIMORE D78469

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1025 S. Third St. ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas O. Richards

(a) RESIDENCE NO. 1025 S. Third St ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. 1 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a ~~Married, widowed, or~~ divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Ella M. Lacpa

6 DATE OF BIRTH (month, day, and year) July 2 -

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
44	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Paint mixer 086

(b) General nature of industry, business, or establishment in which employed (or employer): Paint Establishment

(c) Name of employer: Hirshberg Paint Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Francis Richards

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Annie Bury

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

14 Informant: Bessie Richards

(Address): 1025 S. Third St.

15 Filed AUG 21 1923 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 18 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 14, 1923, to Aug. 18, 1923, that I last saw him alive on Aug. 18, 1923, and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular disease of the heart.

(Mitral insufficiency)

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. Lockbaches, M. D.

, 19 (Address) 806 S. Third St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

DATE OF BURIAL: Aug 21 1923

20 UNDERTAKER: George F. Rich

ADDRESS: 1735 Harford Ave.

Spec.—1-10-21—M&T—1500 Bks.

D78470

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D78470

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2213 Madison ave ST., 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dr. Benjamin L. Kenhausen

(a) RESIDENCE NO. 2213 madison ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Kenhausen

6 DATE OF BIRTH (month, day, and year) July 15 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	27	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physiologist Scientist

(b) General nature of industry, business, or establishment in which employed (or employer) Hopkins Laboratory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Simon A. Kenhausen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Stettins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Baltimore

15 Filed AUG 21 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-20 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 16, 1923, to August 20, 1923, that I last saw h in alive on August 20, 1923, and that death occurred, on the date stated above, at 12.9 m.

The CAUSE OF DEATH* was as follows:

Bright's disease

Chronic Interst Nephritis.

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Pericarditis - Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation Autopsy

(Signed) Joseph L. Kahn, M. D.

(Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 8/21 1923

20 UNDERTAKER Jack Lewis 1439

ADDRESS E Balt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78471

CERTIFICATE OF DEATH.

43 D78471

1-PLACE OF DEATH U. S Marine Hospital #1

CITY OF BALTIMORE: (No. Baltimore Md ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Stevens

(a) RESIDENCE NO. 146 East St. Balto ST. Md. WARD 2

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer) Ste Talbot

(c) Name of employer

9 BIRTHPLACE (city or town) md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant U S marine corps #1
(Address)

15 Filed AUG 21 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/20 1923

17

I HEREBY CERTIFY, that I attended deceased from June 10th 1923 to August 20 1923.

that I last saw him alive on August 20 1923

and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Tongue
primary

(duration) 1 yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. McDevitt A.B., M. D.

8/20 1923 (Address) U. S. Marine Hospital #1

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL 8/21 1923

20 UNDERTAKER S. Thierson & Bro — ADDRESS 1127 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D78472

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

D78472

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Little Sisters of the Poor St., West Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julian Jefferson

(a) Residence No. Preston & Valley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Colored

5-~~Single,~~ ~~Married,~~ Widowed, ~~or Divorced.~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widow Charles Jefferson

6-DATE OF BIRTH (month, day and year) 1845

7-AGE. 78 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Odd

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Camp Hill

11-BIRTHPLACE OF FATHER (city or town) (State or Country).

12-MAIDEN NAME OF MOTHER. Eclen

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant) Sister Florence

(Address) Preston & Valley

15- Filed AUG 21 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 20/23

17- I HEREBY CERTIFY, That I attended deceased from To record 19 to 19

that I last saw h.. alive on Aug 12 1923

and that death occurred, on the date stated above, at 11 30 a m

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemiplegia

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F A Warner M. D

Aug 23, 19 (Address) 1133 Darley Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cemetery — DATE OF BURIAL. Aug 21 1923

20-UNDERTAKER. H. C. Niedefeld — ADDRESS 9th Fremont Ave.

IMPORTANT. PHYSICIANS should state CAUSE OF DEATH EXACTLY. AGE should be stated EXACTLY. OCCUPATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH EXACTLY. Exact statement of OCCUPATION is very important. In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78473

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78473

CERTIFICATE OF DEATH.

128

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 443 E. Gittings ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara G. Cuddy

(a) RESIDENCE No. 443 E. Gittings ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 9, 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John T. Cuddy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Barbara McCleavey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant John T. Cuddy (Address) 443 E. Gittings St

15 Filed AUG 21 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 14, 1923, to Aug 19, 1923, that I last saw h alive on Aug 19, 1923, and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

followed by endocarditis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Epilepsia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinary

(Signed) [illegible], M. D.

8/21, 1923 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem DATE OF BURIAL 8/22/1923

20 UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No history of infection

Spec.—1-10-21—M&T—1500 Bks.

D78474

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D78474

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 837 Clowey ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Edward Driver

(a) RESIDENCE NO. 837 Clowey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriett E. Driver

6 DATE OF BIRTH (month, day, and year) 8/21/1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Jeremiah Driver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emily Conine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Harriett Driver. (Address) 1338 Bentalou Ave.

15 AUG 21 1923 . 19 G. H. Bruce Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/18/1923

17

I HEREBY CERTIFY, That I attended deceased from 8/17 . 1923. to 8/18 . 1923.

that I last saw him alive on 8/18 . 1923.

and that death occurred, on the date stated above, at 3:24 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

Contributory Arterio sclerosis

Duration: yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) G. L. Jackson M. D.

. 19 (Address) 762 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL Aug 21 19 23

20 UNDERTAKER — ADDRESS

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78475 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D78475

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Penitentiary ST.: 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Williams

(a) RESIDENCE. No. 217 N. Mount ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Williams

6 DATE OF BIRTH (month, day, and year) 1895.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrical 024

(b) General nature of industry, business, or establishment in which employed (or employer) Lineman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York City.

PARENTS

10 NAME OF FATHER Charles Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant W. S. Wrzzy (Address) Warden

15 Filed AUG 21 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August - 18 - 1923

17 I HEREBY CERTIFY, That I attended deceased from February - 21, 1923, to August - 18, 1923, that I last saw him alive on August - 18, 1923, and that death occurred, on the date stated above, at 3 12 P. m.

The CAUSE OF DEATH* was as follows:

Toxemia, Exhaustion and Pulmonary Tuberculosis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus.

(duration) yrs. 5 mos. 27 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination Sputum & urine

(Signed) William F. Schwartz, M. D.

8/19, 1923 (Address) Maryland Penitentiary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	May 21 1923
20 UNDERTAKER	ADDRESS 1130
Brown & Berlands	Edmondson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec- 12-23-21-E.B.R.S.-400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78476 X 31 D78476

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 230 N. Green St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. Baptist Tanner (Tanner)

(a) Residence No. 230 N. Green St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 9 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, Colored

5-Single, Married, Widowed or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Annie B Tanner

6-DATE OF BIRTH (month, day and year) Mr 7

7-AGE, 39 yrs. 9 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Tanner 086

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Va.

PARENTS

10-NAME OF FATHER, Nathaniel Tanner

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Stell

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Va.

11- (Informant) Annie B Tanner

(Address) 230 N Green St

15- Filed AUG 21 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 18-1923

17- I HEREBY CERTIFY, That I attended deceased from July 9 1923 to Aug. 18 1923

that I last saw him alive on Aug 15 1923

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage (Duration) yrs. mos. 5 days

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) R. C. Mekell M. D

Aug 19. 1923 (Address) 1903 W. North ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Loudon Park Bur	Aug 21. 1923
20-UNDERTAKER.	ADDRESS
W M Routson	2238 N Howard

NOTE—PHYSICIANS should state CAUSE OF DEATH EXACTLY. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. Be sure to state in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Be sure to state in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78477

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D78477

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 20 East Belvidere ST., 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Rachel Utz (Utz)

(a) RESIDENCE No. 26 East Belvidere ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	83	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll County Maryland

PARENTS

10 NAME OF FATHER Jacob Ulyers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lydia Ensor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Alice Baker
(Address) 20 East Belvidere Ave

15 Filed AUG 21 1923, 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1923

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923, to Aug 20, 1923, that I last saw her alive on Aug 15, 1923, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Charles J Wells, M. D.

, 19 (Address) 7 W Baltimore Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mountain View Cem Md

DATE OF BURIAL Aug 22 1923

20 UNDERTAKER H Maurice Rouleau

ADDRESS 2238 N Milton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

OODAK

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78478

CERTIFICATE OF DEATH.

161-00 D78478

1-PLACE OF DEATH

REGISTERED NO. C

CITY OF BALTIMORE: (No. 13 S. Robinson ST.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Marie Braun (Braun)

(Residence in Baltimore: No. 13 S. Robinson St. St.; yrs., mos., ds.)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should take care CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
F	White	Single

6-DATE OF BIRTH, Dec 11, 1922
(Month) (Day) (Year)

7-AGE,	If LESS than 1 day,
yrs. 8 mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Albert Braun

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Mary M. Schinck

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Braun

(Address) 13 S. Robinson St.

15-

Filed AUG 21 1923, 19..

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 19, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 11 1922, to Aug 19 1923, that I saw h... alive on Aug 19 1923, and that death occurred, on the date stated above, at 7:30 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial
Chronic Nephritis

(Duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

(Signed) ... M. D.

8/19, 1923 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Patricks Cemetery — DATE OF BURIAL, Aug. 21 1923

20-UNDERTAKER J. A. Moran — ADDRESS 3000 E Baltimore St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78479

CERTIFICATE OF DEATH.

31 D78479

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 S. Chester ST., 2 WARD)

2-FULL NAME Frank Stephen Bunk

(a) RESIDENCE NO. 416 S Chester ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 33 yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Bunk

6 DATE OF BIRTH (month, day, and year) Apl 16-1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Freight Car Shops

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Europe

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Rosa Bunk
(Address) 416 S Chester

15 Filed AUG 21 1923 19 GS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1923

17

I HEREBY CERTIFY, That I attended deceased from June 18, 1923, to Aug 19, 1923, that I last saw h living alive on Aug 18, 1923 and that death occurred, on the date stated above, at 3 00 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edward J Lewis M. D.

Aug 20, 1923 (Address) 413 E Washington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	aug 22 1923
20 UNDERTAKER	**ADDRESS**
John H Weber	1803 Bank St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D78480

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78480

CERTIFICATE OF DEATH.

5 90

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 25-8 N. Colvin St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Walter Reed

(Residence in Baltimore: No. 25-8 N. Colvin St.; yrs., 15 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Col.	Single

6-DATE OF BIRTH. 1881
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
42 yrs. ..... mos. ..... ds.	....hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Driver
(b) General nature of industry, business, or establishment in which employed (or employer)..... 23

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER. Boyd Reed

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Mary Bonnie

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carrie Martin

(Address) 700 N. Eden St.

15-

Filed AUG 21 1923 G.C., Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. August 19, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to.....death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Primary Cerebral Apoplexy

Duration..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration)..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
(Coroner.)

Aug 20 1923 (Address) [illegible]

*State the **Disease Causing Death**, or, in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal**, or **Homicidal.**

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Arlington Cemetery	Aug 22 1923

20-UNDERTAKER.	ADDRESS
J. T. H. Rockville	[illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78481

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

D78481

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat St.: 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Joseph.

(a) RESIDENCE. No. Mt Hope Retreat St., 26 Ward. Resident

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred about 40 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 80 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) about 1836

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	87	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Felix Mutz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Hartung

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mt Hope Retreat (Address)

15 Filed ... 19... Registrar

UG 11 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1923, to August 21, 1923, that I last saw h.r alive on August 20, 1923, and that death occurred, on the date stated above, at 2. a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Senile degeneration

(duration) unknown yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical - Medical

(Signed) Wilbur P. Hall, M. D.

, 19 (Address) 1715 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Hope Cemetery — DATE OF BURIAL Aug-22 1923

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Manager) — ADDRESS 108 W. NORTH AVE

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78482

CERTIFICATE OF DEATH.

31 D78482

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5h) St. Josephs (St.) (WARD) 19

2-FULL NAME Anna Belle Moan

(a) RESIDENCE NO. 1424 N. Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State) Lifetime

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER James Moan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherine Feaney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mary Good

(Address) 2625 E. Lewis St

15 Filed 8/21 1923, 19 Robert P. Harrison, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1923, to Aug 19, 1923, that I last saw h[er] alive on Aug 19, 1923, and that death occurred, on the date stated above, at 11.45 p m.

The CAUSE OF DEATH* was as follows:

Central Lumpneumy

(duration) Unknown yrs. mos ds.

CONTRIBUTORY (Secondary) General Tuberculosis

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Harry A Stein M. D.

8/20 1923 (Address) 1315 Eut Royal Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 8/23 1923

UNDERTAKER Chas. P. Evans & Son

ADDRESS 1181 E. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary Tuberculosis

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78483

CERTIFICATE OF DEATH.

113 D78483

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3600 Ash St ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm Howard Hoy

(a) RESIDENCE. No 3600 Ash St ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 18 1923

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles T Hoy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mamma V Hanes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Charles T Hoy
(Address) 3600 Ash St

15 Filed AUG 21 1923, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/19— 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1— 1923, to Aug 19 1923, that I last saw him alive on Aug 18— 1923, and that death occurred, on the date stated above, at 3 40 P.M.

The CAUSE OF DEATH* was as follows: Gastro Enteritis

(duration) yrs. — mos. 20 ds.

CONTRIBUTORY (Secondary) Debilitation Infantile

(duration) yrs. — mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Presumptive Symptoms

(Signed) A Lee Hanff M. D.

, 19 (Address) 1340 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Cem Hampden Md	8/21 1923

20 UNDERTAKER GRENOWETH & SON. ADDRESS 3617 CHESTNUT AVE.

Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78484

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78484

CERTIFICATE OF DEATH.

113

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 248 S Ann ST., 2 WARD)

2-FULL NAME Vincent Domkus

(a) RESIDENCE No. 248 S Ann ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of - -

6 DATE OF BIRTH (month, day, and year) March 24. 1923

7 AGE Years 4 Months 27 Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work - -

(b) General nature of industry, business, or establishment in which employed (or employer) - -

(c) Name of employer - - -

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Vincent Domkus

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithvania

12 MAIDEN NAME OF MOTHER Mary Palulis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md.

14 Informant Vincent Domkus
(Address) 248 S Ann Street

15 Filed AUG 21 1923, 19.. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20. 1923

17 I HEREBY CERTIFY, That I attended deceased from June —, 19 23, to Aug- 21, 19 23,
that I last saw h— alive on Aug 21, 19 23,
and that death occurred, on the date stated above, at 4 P- m.
The CAUSE OF DEATH* was as follows:

Peritonitis - Enteritis due
to Intussusception (duration) .. yrs. 2 mos 1/2 ds.
CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? ✓
Did an operation precede death? no Date of —
Was there an autopsy? ✓
What test confirmed diagnosis? ✓
(Signed) [illegible] M. D.
, 19 (Address) 125 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Aug. 22. 1923
20 UNDERTAKER	ADDRESS
John Grebliauckas	425 S Paca St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONDITION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

(Wilson)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78485

CERTIFICATE OF DEATH.

168 D78485

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 905 Cathedral St., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Norman Wilson

(a) RESIDENCE NO. 905 Cathedral ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Emily Wilson

6 DATE OF BIRTH (month, day, and year) June 8, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Penn.
(State or country)

PARENTS

10 NAME OF FATHER Norman Wilson

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Kate Hudson

13 BIRTHPLACE OF MOTHER (city or town) Scotland
(State or country)

14 Informant Emily Wilson
(Address) 905 Cathedral

15 Filed AUG 21 1923, 192 Robert P. Harrison, Registrar

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 192 3

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Suicide by Laudanum while
Temporary Insane (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)
Aug 21, 192 3 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk, Va	Aug 21, 1923
20 UNDERTAKER	ADDRESS
Wm Lenk & Son	Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78486

CERTIFICATE OF DEATH.

113 D78486

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 704 Cider Alley ST., 4 WARD)

2-FULL NAME George Donaldson

(a) RESIDENCE NO. 704 Cider Alley ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 30, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	1	—	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER George Donaldson

11 BIRTHPLACE OF FATHER (city or town) North Carolina
(State or country)

12 MAIDEN NAME OF MOTHER Lilly Johnson

13 BIRTHPLACE OF MOTHER (city or town) North Carolina
(State or country)

14 Informant Lilly Donaldson
(Address) 704 Cider alley

Filed AUG 21 1923, 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20th 1923

17

I HEREBY CERTIFY, That I attended deceased from August 18, 1923, to August 20th, 1923, that I last saw him alive on August 18th, 1923, and that death occurred, on the date stated above, at 3.P m.

The CAUSE OF DEATH* was as follows:

Rickets (duration) — yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) Enteri Colitis (duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Edward E Mackenzie M. D.

Aug 21, 1923 (Address) 1339 N Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 8-22-1923

20 UNDERTAKER David Easters

ADDRESS 916 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78487 99-001 D78487

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 810 Hanford ave ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert F Fisher

(a) RESIDENCE. NO. 810 Hanford ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	col-	child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of child

6 DATE OF BIRTH (month, day, and year) July 9- 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
2 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto md

PARENTS

10 NAME OF FATHER John Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER mary Todd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant John Fisher
(Address) 810 Hanford ave

15 Filed ..... 19.. Robert P. Harrison Registrar

AUG 21 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20 1923

17 I HEREBY CERTIFY That I attended deceased from Aug 20 1923 to (One Day) that I last saw him alive on Aug 20 1923 and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Edema Epiglottis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Bronchitis acute

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 810 Hanford ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W R Boykin, M. D.

, 19 (Address) 616 Calhoun

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk Va Norfolk va	aug 21 1923
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Eutaw pl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every [illegible] of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

1576

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D78488

D78488

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinking Home Norwood ST., 19 WARD)

2-FULL NAME Alice Bruce Southerland

(a) RESIDENCE NO. 2727 Maryland ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: single

6 DATE OF BIRTH (month, day, and year): Dec. 1853

7 AGE: Years 69 Months 8 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Silas B. Southerland

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Margaret K. Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Silas B. Southerland Jr.

(Address) 2727 Maryland ave

15 Filed , 19 Registrar

AUG 21 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 19th, 1923, to August 20th, 1923, that I last saw her alive on August 19th, 1923, and that death occurred, on the date stated above, at 5:- A.M.

The CAUSE OF DEATH* was as follows:

Cardiac hypertrophy. Mitral regurgitation + Endocarditis.

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary): Edema

(duration) yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

What test confirmed diagnosis? Aut

(Signed) J. Rhys Nicoll M. D.

(Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Augt 22 1923

20 UNDERTAKER: John Ortel Bell — ADDRESS: 1211 N. Fayette St.

IMPORTANT.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D78489

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78489

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Gorman

(a) Residence No. 18 N. Stricker St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Gorman

6-DATE OF BIRTH (Month, day and year) Sept 15 1861

7-AGE, 52 yrs. 11 mos. 5 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... 009

(b) General nature of industry, business, or establishment in which employed (or employer) Clerk

(c) Name of employer.....

9-BIRTHPLACE (city or town) Balto (State or Country),

PARENTS.

10-NAME OF FATHER, Nicholas Gorman

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Barbara Carr

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Hospital Records

(Address).....

15- Filed..... Robert P. Harrison, Registrar.

AUG 21 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/21/23

17- I HEREBY CERTIFY, That I attended deceased from 8/11/23, 19.. to 8/20/23, 19.. that I last saw h.. alive on 8/20/23, 19.. P and that death occurred, on the date stated above, at 10.30 m.

The CAUSE OF DEATH* was as follows:

Malangitis (Purulent)

(Duration) yrs. 2 mos. 15 ds.

CONTRIBUTORY (Secondary) Shock - Exhaustion

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ? Drainage of Gall Bladder

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) K. W. Goldley M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Holy Redeemer Cem. DATE OF BURIAL, 8/23/23

20-UNDERTAKER, Gold Finley Fulford ADDRESS Lafayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of this information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78490 ✓ 90 D78490

CERTIFICATE OF DEATH.

1-PLACE OF DEATH I533 W. Lombard St.,

CITY OF BALTIMORE: (NO. I533 W. Lombard St., ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth L. Barton,

(a) RESIDENCE NO. I533 W. Lombard St., ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred II yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Barton

6 DATE OF BIRTH (month, day, and year) April 12, 1839

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
84	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Vermont

PARENTS

10 NAME OF FATHER McDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

14 Informant Belle Landon

(Address) I533 W. Lombard St.,

15 Filed AUG 21 1923, 19 Registrar

Burial Permit Given.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1921, to Aug 21, 1923, that I last saw her alive on Aug 21, 1923, and that death occurred, on the date stated above, at 8.15 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Contributory (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex.

(Signed) Henry E. Ohler, M. D.

, 19 (Address) 1203 N. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bennington, Vermont

DATE OF BURIAL Aug 24 1923

20 UNDERTAKER Harry E. Witzke

ADDRESS 1522 Lombard St

A B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78491

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78491

CERTIFICATE OF DEATH.

1-PLACE OF DEATH: John Hopkins Hospital — Registered No. C 109-001

City of BALTIMORE: (No. ... St., ... Ward)

2-FULL NAME: Harry E. Jackson

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 808 N. Port St.; yrs., ... mos. ... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Single

6-DATE OF BIRTH: April 7 1923
(Month) (Day) (Year)

7-AGE: 1 yrs. 4 mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): do

9-BIRTHPLACE (State or Country): Balto Md

PARENTS.

10-NAME OF FATHER: Harry E. Jackson

11-BIRTHPLACE OF FATHER (State or Country): Balto Md

12-MAIDEN NAME OF MOTHER: Mary E. Hoar

13-BIRTHPLACE OF MOTHER (State or Country): Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Harry E. Jackson

(Address): 808 N. Port St

15-

Filed Aug 22, 1923

Robert F. Harrison, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Aug 20 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows:

Bronchopneumonia

(Duration) ... yrs. ... mos. 1 da.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Geo. M. Morrison M. D.
(Coroner.)

1923 (Address) 2021 Eden

(State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Mt. Carmel Cem — DATE OF BURIAL: 8/22 1923

20-UNDERTAKER: Wm Cook — ADDRESS: 503 E. North Ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.

Spec.—1-10-21—M&T—1500 Blks.

D78492

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D78492

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 421- N. Pine St., 17 WARD)

2-FULL NAME Wm Emanuel Simms

(a) RESIDENCE NO. 421- N Pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Blk	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 27/22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	1	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Phillip Simms

11 BIRTHPLACE OF FATHER (city or town) Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Dailey

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Minnie Dailey
(Address) 421 N Pine St

15 Filed AUG 21 1923 19 G G Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1923

17 I HEREBY CERTIFY, That I attended deceased from 8/18, 1923, to 8/20, 1923, that I last saw him alive on 8/20, 1923, and that death occurred, on the date stated above, at 5.25 P m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Convulsions.

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Gustav Gothman, M. D.

, 19 (Address) 66 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Aug 22 1923
20 UNDERTAKER	ADDRESS
C. W. Bramble's Son	1011 E. Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Intestinal

Spec.—6-9-19—H. P. Co.—1000 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78493 D78493

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. Monument ST.: 3 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac Lipsitz

(a) RESIDENCE. NO. 141 S. Central ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAKE NO ERASURES OR CORRECTIONS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
MALE	WHITE	MARRIED

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jennie Lipsitz

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pants Presser

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jennie Lipsitz
(Address) 141 S. Central Ave

15 Filed AUG 22 1923 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1923, to Aug 21, 1923, that I last saw h[illegible] alive on Aug. 21, 1923, and that death occurred, on the date stated above, at 2.45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver with Metastases.

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of June 28, '23

Was there an autopsy?

What test confirmed diagnosis? Clinical + Laboratory

(Signed) Isadore L. Jay, M. D.

8/22 1923 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rodeph Shalom	8-22 1923
20 UNDERTAKER Jack Levin	ADDRESS 1439 Eutaw

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

John L. Sommer Jr ✓

D78494 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11 3 D78494

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1017 Light St ST. 24 WARD)

2-FULL NAME John R Sommer Jr.

(a) RESIDENCE NO. 1017 Light St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) July 11 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John R Sommer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sophia Kaskel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) John R Sommer 1017 Light St

15 AUG 22 1923 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-21-1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 5, 1923, to Aug 21, 1923, that I last saw him alive on Aug 20, 1923, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Enteritis.

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) Wm L Seabury, M. D.

Aug 21, 1923 (Address) 638 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross a a Co. — DATE OF BURIAL 8-22 1923

20 UNDERTAKER E & B Hanlon 115 — ADDRESS E West St

D78495

D78495

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED No. C 168

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Mt. Hope Retreat WARD) 15

2-FULL NAME John Ernstberger

(Residence in Baltimore: No. 2325 ~~Pennsylvania~~ W. North ave.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

St.; yrs. 57 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX male

4-COLOR OR RACE, white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) widower

6-DATE OF BIRTH, March 6, 1866
(Month) (Day) (Year)

7-AGE, 57 yrs. 6 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Painter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, Frank H. Ernstberger

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Johanna King

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mt. Hope Retreat

(Address) Balto. Md.

15- Filed AUG 22 1923 191.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 21, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by hanging

(Duration)..... yrs..... mos..... ds.

CONTRIBUTORY (Secondary) Manic depression

(Duration) 6 yrs. 6 mos..... ds.

(Signed) D. T. Hennessy M. D.
(Coroner.)

August 24 1923 (Address) 1802 Eastern Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL, OR REMOVAL, Cathedral Cem. DATE OF BURIAL, Aug. 23, 1923

20-UNDERTAKER Martin Fahey & Son ADDRESS 1837 W South

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78496

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78496

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1327 Holbrook ST.: 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Wyman

(a) RESIDENCE. NO. 1327 Holbrook ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Joseph H Wyman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind

PARENTS

10 NAME OF FATHER Patric Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Irland

12 MAIDEN NAME OF MOTHER Hattie Slemmons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Irland

14 Informant Jos H Wyman (Address) 1327 Holbrook st

15 Filed ..... 19 ..... Registrar

AUG 22 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1 1923 to Aug. 20 1923.

that I last saw h alive on 19

and that death occurred, on the date stated above, at 420 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 2 mos. 20 ds.

CONTRIBUTORY (Secondary) [redacted]

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) J. Brumbaugh M. D.

(Address) 1531 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	Aug 23 1923

20 UNDERTAKER ADDRESS

CHENOWETH & SON
3017 CHESTNUT AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Labórer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.). "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history

Spec.—1-10-21—M&T—1500 Bks.

D78497

D78497

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bay View Hospital (WARD) 7

2-FULL NAME Jennie Tull

(a) RESIDENCE NO. 1814 Ashland Ave ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of [illegible]

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) Unknown.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) Unknown.
(State or country)

14 Informant Rebecca Reynolds
(Address) 1814 Ashland Ave

15 Filed AUG 22 1923, 19.... Registrar H. A. Mc

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 19, 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1, 1923, to Aug. 19, 1923, that I last saw her alive on Aug. 18, 1923, and that death occurred, on the date stated above, at 7.50 a. m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) General Paralysis (Luetic) (duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) H. Feldmeyer M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathay Cemetery — DATE OF BURIAL Aug 22 1923

20 UNDERTAKER Wm. R. C. Elliott — ADDRESS 1214 Eastlander

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78498

CERTIFICATE OF DEATH.

1007

188 D78498

1-PLACE OF DEATH

City of BALTIMORE: (No. 1932 W. Fairmount Ave Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Schultheis

(Residence in Baltimore: No. 1932 W. Fairmount ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, ~~Widowed, or Divorced~~, (Write the word.): Married

6-DATE OF BIRTH: July (Month) 15th (Day) 1863 (Year)

7-AGE: 60 yrs. 1 mos. 7 ds. If LESS than 1 day, ~~hrs. or min.~~

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Blksmith
(b) General nature of industry, business, or establishment in which employed (or employer): Inspector B.

9-BIRTHPLACE, (State or Country): Baltimore

PARENTS:

10-NAME OF FATHER: William Schultheis

11-BIRTHPLACE OF FATHER, (State or Country): Baltimore Md

12-MAIDEN NAME OF MOTHER: Elizabeth Hach

13-BIRTHPLACE OF MOTHER, (State or Country): Baltimore

11-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs William Schultheis

(Address) 1932 W. Fairmount ave

13-

Filed AUG 22 1923 192.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 17 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Injuries from Motor Cycle
Accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) (Coroner.) M. D.

1923 (Address) 1192 Roland ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Aug. 22, 1923

20-UNDERTAKER, George J. Ruth — ADDRESS 1735 Harford Ave.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78499

CERTIFICATE OF DEATH.

45 D78499

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hosp., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Elder

(a) RESIDENCE NO. 1736 N. Darley Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/20/1858

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	65	2	=	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Elder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Bush

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) Mrs. Elder 1736 Darley Ave

15 Filed AUG 22 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-20-1923

17

I HEREBY CERTIFY, That I attended deceased from 7-28-1923, to 8-20-1923, that I last saw him alive on 8-20, 1923, and that death occurred, on the date stated above, at 12:10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of sigmoid.

(duration) yrs. 8 mos — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X ray & exam.

(Signed) Dr E. Hall M. D.

8-20-1923 (Address) 1617 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	8/23/23
20 UNDERTAKER	ADDRESS
George J. Reilly	1331 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78500 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 D78500

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 S. Regester ST., 7 WARD)

2-FULL NAME Elizabeth Slitzer

(a) RESIDENCE NO. 417 S. Regester ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 27th 1900

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
23	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Louis Slitzer.

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Josephine Bamberger

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md.
(State or country)

14 Informant Josephine Slitzer.
(Address) 417 S. Regester St.

15 Filed AUG 22 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 18th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1923, to Aug 18, 1923, that I last saw he alive on 11 18, 1923, and that death occurred, on the date stated above, at 7 20 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical signs

(Signed) C. D. Heer, M. D.

19 (Address) 408 Ballaran Park Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Aug 22 1923
20 UNDERTAKER Lilly & Zeiler	ADDRESS 403 S. Wolfe

Spec.—8-24-14—M. & T.—2000 Bks.

D78501

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78501

CERTIFICATE OF DEATH.

90

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3412 Gwynns Falls Parkway ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances C. Marsden

(Residence in Baltimore: No. 3412 Gwynns Falls Parkway St.; Life yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widow

6-DATE OF BIRTH, May (Month) 22 (Day) 1863 (Year)

7-AGE, 60 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer)..... 000

9-BIRTHPLACE, (State or Country), Balto md

PARENTS.

10-NAME OF FATHER, Jeremiah Carey

11-BIRTHPLACE OF FATHER (State or Country), Ireland

12-MAIDEN NAME OF MOTHER Ann Lions

13-BIRTHPLACE OF MOTHER (State or Country), Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James T. Kelly

(Address) 3412 Gwynns Falls Pkway

15-

Filed AUG 22 1923 191.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 20 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 15 a. 1923, to Aug 20 1923, that I saw her alive on Aug 19 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) Several yrs. mos. ds.

CONTRIBUTORY (Secondary) Organic Heart disease

(Duration) yrs. 3 mos. ds.

(Signed) Leonard E Koch M. D.

Aug 21, 1923 (Address) 2331 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
H. C. New Cathedral	Aug 23, 1923
20-UNDERTAKER	ADDRESS
H. Brauning's Son	517 N. Schroeder st

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78502

CERTIFICATE OF DEATH.

73 ✓ D78502

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 S Washington ST., 2 WARD)

2-FULL NAME Andrew Mueller

(a) RESIDENCE NO. (411) 411 S Washington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. — mos. — ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ late Elizabeth Mueller

6 DATE OF BIRTH (month, day, and year) Mar 2/51

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Grocer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs H Mueller

(Address) 411 S Washington

15 Filed AUG 22 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 19 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1923 to Aug 19 1923, that I last saw h... alive on ... 19..., and that death occurred, on the date stated above, at 7 15 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans (Shaking Palsy)

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Wm C Bratton M. D.

, 19 (Address) 125 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL 8/23 1923

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(Ferris I. Carl)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78503

CERTIFICATE OF DEATH.

113

D78503

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3055 Hamburg) ST., 24 WARD)

2-FULL NAME Ferris I Carl

(a) RESIDENCE NO. 3055 Hamburg ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 8 1923

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER John O Carl

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Olivia D Powell

13 BIRTHPLACE OF MOTHER (city or town) Dorchester Co Md (State or country)

14 Informant John O Carl (Address) 308 E Hamburg

15 Filed AUG 22 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 19 1923, to Aug 20th 1923, that I last saw her alive on Aug 20th 1923, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

Watery (duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry B Kolb M. D.

Aug 21 1923 (Address) 1203 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Aug 22 1923
20 UNDERTAKER Gruber & Gruber	ADDRESS 1739 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

FRANK SIERAK.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78504 31 D78504

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2417 Foster Ave. 1 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Sierak

(a) RESIDENCE NO. 2417 Foster Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 15 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wood top factory

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Anton Sierak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Bzdonich

13 BIRTHPLACE OF MOTHER (city or town) Pole Rostkowo (State or country) Poland

14 Informant (Address) 2417 Foster Ave.

15 Filed AUG 22 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1923, to Aug 20, 1923, that I last saw h— alive on Aug. 20, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical

(Signed) G F Rees, M. D.

Aug 21, 1923 (Address) 24 E Pleasant

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. DATE OF BURIAL Aug. 23, 1923.

20 UNDERTAKER M. J. Sadowski ADDRESS 905 S. Ann St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78595

CERTIFICATE OF DEATH.

90 D78595

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 131 W Hamburg ST.; 23 WARD)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles W Dawney

(Residence in Baltimore: No. 131 W Hamburg St.; yrs. 65 mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, May 16, 1 (Month) (Day) (Year)

7-AGE, 64 yrs. ..... mos. ..... da. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Odd

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Wm Downey

11-BIRTHPLACE OF FATHER (State or Country), Maryland

12-MAIDEN NAME OF MOTHER Dont know

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary E. Downey

(Address) 131 W. Hamburg

15-

Filed AUG 22 1923 .....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 21 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 12 1923, to August 12 1923, that I saw h 10 alive on August 12 1923, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Heart Disease

J a malaise

(Duration) ..... yrs. ..... mos. 5 da.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... da.

(Signed) Thomas H Bauer M. D.

(Address) 1211 W Hamburg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cedar Hill — DATE OF BURIAL, Aug 23, 1923

20-UNDERTAKER Wm Cook — ADDRESS 502 E Monument

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Butler)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78506

100-001

D78506

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gassaway Hall Butler

(a) RESIDENCE No. 2130 W. North Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 11 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgieanna Jamaima Butler

6 DATE OF BIRTH (month, day, and year) Aug 15 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cub Hill Baltimore Co. Md

PARENTS

10 NAME OF FATHER Gassaway Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Mary Wyley

13 BIRTHPLACE OF MOTHER (city or Stamford Co (State or country) Md

14 Informant Miss Laura M. Butler

(Address) 2130 W. North Ave.

15 Filed AUG 22 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 18, 1923, to Aug 21, 1923, that I last saw h alive on Aug 21, 1923, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

Bronchio-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nervous Retention

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8-20-23

Was there an autopsy? No. Clinical findings

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	Aug 24 1923

20 UNDERTAKER Wm Cook | ADDRESS 508 E North

D78507

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78507

CERTIFICATE OF DEATH.

REGISTERED No. C 114

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) John Hopkins Hospital ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond Farr.

(Residence in Baltimore: No. 2511 Orleans St. St.; yrs. Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-SINGLE, ~~MARRIED~~, WIDOWED, ~~OR DIVORCED~~, (Write the word.)

6-DATE OF BIRTH, June 16, 1920 (Month) (Day) (Year)

7-AGE, 2 yrs. 9 mos. 5 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Baltimore Md

PARENTS.

10-NAME OF FATHER, William R Farr

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Ethel M. Otto

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Ethel M. Farr

(Address) 2511 Orleans St

15-

Filed AUG 22 1923, 19.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 21, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Consumption

.....

.....

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

.....(Duration).....yrs.....mos.....ds.

(Signed) John H. Norman M. D.
(Coroner.)

Aug 22, 1923 (Address) 2522 Poland C

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cemetery

DATE OF BURIAL, Aug 23, 1923

20-UNDERTAKER Mrs. E. Miller

ADDRESS 2334 Jefferson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D.A.K. S.A.F.E.

Spec.—1-10-21—M&T—1500 Bks.

D78508 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 84 D78508

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., 4 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Furbee
Salem, W. Va.

(a) RESIDENCE NO. ..... ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. 18 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 10 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	10	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Business (Hotel)
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) West Virginia

PARENTS

10 NAME OF FATHER James Furbee

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) West Virginia

12 MAIDEN NAME OF MOTHER [redacted] Colburn

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) West Virginia

14 Informant University Hospital Records
(Address) Baltimore Md

15 Filed AUG 22 1923 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 4 .1923. to Aug 22 .1923.
that I last saw her alive on Aug. 22 .1923.
and that death occurred, on the date stated above, at 7:10 a m.
The CAUSE OF DEATH* was as follows:
Brain tumor (Glioma)

(duration) yrs. 5 mos ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis? Clinical findings
(Signed) John M. Edmonds, M. D.
, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Salem West Va	Aug 22 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78509

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

90 D78509

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 714 N. Carrollton Av ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Medora Sophia Cook

(a) RESIDENCE. NO. 714 N. Carrollton ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 ~~Single, Married,~~ Widowed, ~~or Divorced~~ (write the word) widow

5a If married, widowed, or divorced ~~HUSBAND of (or) WIFE of~~ wife of Joseph Cook

6 DATE OF BIRTH (month, day, and year) Jan 15 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
88		7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Roelkey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Drier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Jos. L. Hodes

(Address) 714 N. Carrollton

15 Filed AUG 22 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-19- 1923

17 I HEREBY CERTIFY, That I attended deceased from 8-15-, 1923, to 8-19-, 1923, that I last saw h[illegible] alive on 8-18-, 1923, and that death occurred, on the date stated above, at 5-[illegible] p. m.

The CAUSE OF DEATH* was as follows:

Generalized senility—
myocardial fibrosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility (duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical history

(Signed) Wm. Reid, M. D.

, 19 (Address) Fidelity Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Aug 22 1923
20 UNDERTAKER Joseph L. B. Cook	ADDRESS 1003 N. Balto St.

Cor.—1-12-23—M&T—100 Bks.

Alice Butler ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78510 D78510

CERTIFICATE OF DEATH.

179

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hospital WARD)

2-FULL NAME alice Butler

(a) RESIDENCE No. 335 Slate St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 03 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of L

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	03		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) H
(c) Name of employer Archer Laundry

9 BIRTHPLACE (city or town) .....
(State or country) Md

PARENTS

10 NAME OF FATHER John Woodland

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Brooks

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Miss Butterman
(Address) [illegible]

15 Filed DEC 23 1923, 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-20 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Severly burned on body

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner.), M. D.

....., 192 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Dr Baker Sun Dr Mayo

DATE OF BURIAL 8-23 1923

20 UNDERTAKER David Earnest

ADDRESS Same

N. B.—WRITE PLAINLY, WITH UNFADING INK. ALL THE DATA REQUIRED UNDER EACH HEADING should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS mation should be carefully supplied. AGE should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D78511

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D78511

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Roche

(a) RESIDENCE NO. 658 W. Redwood St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James B. Roach.

6 DATE OF BIRTH (month, day, and year) 3-2 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	71	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Samuel Perkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed AUG 22 1923 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 21 19 23

17 I HEREBY CERTIFY, That I attended deceased from April 17, 19 22, to August 21, 19 23, that I last saw her alive on August 20, 19 23, and that death occurred, on the date stated above, at 8:00 A.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (Terminal) (duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Claude G. Howe M. D.

8-21 1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 8/23 1923

20 UNDERTAKER J. Frew McCully — ADDRESS 130 E. Fort

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78512

CERTIFICATE OF DEATH.

101-001 ✓ D78512

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST. 22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen Shugay

(a) RESIDENCE No. 428 S. Paca St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Henry Shugay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Municipal Hospital Records. (Address) UNIVERSITY OF MARYLAND.

15 Filed ..., 19 Registrar

AUG 22 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 20 1923

17

I HEREBY CERTIFY, That I attended deceased from July 18, 1923, to August 20, 1923

that I last saw him alive on August 20, 1923

and that death occurred, on the date stated above, at 10:45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Pneumonia (Non-Tuberculous)

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. X-ray

(Signed) Claude B. Hayes M. D.

8-21-1923 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL ..., 19

20 UNDERTAKER

ADDRESS

Department of Health, AUG 22 1923

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78513

CERTIFICATE OF DEATH.

D78513

REGISTERED NO. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3201 Windsor Avenue ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Joseph Albert

(a) RESIDENCE NO. 3201 Windsor Avenue ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 1 mos. 17 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna T. Mulhern

6 DATE OF BIRTH (month, day, and year) July 3, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Wholesale and

(b) General nature of industry, business, or establishment in which employed (or employer) Retail Meat Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Albert

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Hartmaier

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Anna T. Albert
(Address) 3201 Windsor Avenue

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 20th 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1922, to Aug 20th, 1923.

that I last saw him alive on Aug. 20th, 1923,

and that death occurred, on the date stated above, at 10.05 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Larynx, and both Lungs. Also tuberculosis of right knee.

(duration) 1 yrs. - mos ds.

CONTRIBUTORY (Secondary)

(duration) - yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isaac C. Dickson, M. D.

, 19 (Address) 3055 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	8/23 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78514

CERTIFICATE OF DEATH.

D78514

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 9 Prospect Circle ST., 15 WARD)

2-FULL NAME Julia Hawley Bolton

(a) RESIDENCE NO. 9 Prospect Circle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George H Bolton

6 DATE OF BIRTH (month, day, and year) April 21, 1857

7 AGE — Years: 66 — Months: 4 — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Piedmont (State or country) West Virginia

PARENTS

10 NAME OF FATHER W. Franklin Hawley

11 BIRTHPLACE OF FATHER (city or town) Salisbury (State or country) New Hampshire

12 MAIDEN NAME OF MOTHER Emily Betson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs Andrew Jackson Woodson (Address) 9 Prospect Circle Windsor Hills

15 Filed AUG 22 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 21 1923

17 I HEREBY CERTIFY, That I attended deceased from August 11, 1923, to August 21, 1923, that I last saw her alive on August 20, 1923, and that death occurred, on the date stated above, at 4.10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis Cutaneous

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. A. O'Neill, M. D.

(Address) 108 N Dutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Aug 23 1923

20 UNDERTAKER: George J Smith — ADDRESS 1532 Hollins st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78515

CERTIFICATE OF DEATH.

D78515

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1318 Harlem ave St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary E Wright

(a) Residence No. 1318 Harlem ave St., ... Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Riley E Wright

6-DATE OF BIRTH (month, day and year) July 29, 1837

7-AGE. 86 yrs. ..... mos. 23 ds.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Mass

PARENTS:

10-NAME OF FATHER. Isaac Collier

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Mass

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Riley E. Wright

(Address) 1318 Harlem Ave

15- Filed ..... 192.....

AUG 22 1923

Robert F. [illegible]
Burial Permit Clerk.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 21 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug-1- 1921 to Aug 21-1923

That I last saw her alive on Aug-21- 1923

and that death occurred, on the date stated above, at 2.50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left Breast

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? yes Date of Aug 1921

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) Marion W Shook M. D

Aug 22 1923 (Address) 8064 Fulton ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Loudon Park	Aug 24 1923
20-UNDERTAKER. George J Smith	ADDRESS 153 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Bks.

D78516

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D78516

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2121 W.Mulberry St. ST., 20 WARD)

2-FULL NAME Louisa C.Gray

(a) RESIDENCE NO. 2121 W.Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 11 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Gray

6 DATE OF BIRTH (month, day, and year) Aug.26 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John C.Meredith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Louisa Small

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Jacob Gray

(Address) 2121 W.Mulberry St.

15 Filed ..... 19 ..... Registrar

AUG 21 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug.21 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 20. 1923. to Aug 20 1923.

that I last saw h[illegible] alive on Aug 20 1923

and that death occurred, on the date stated above, at 7[illegible] a.m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there ~~an autopsy~~? No

What test confirmed diagnosis? —

(Signed) Wm A. Duvall M. D.

19 (Address) 3523 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union Bridge Md (Via Antrim) DATE OF BURIAL Aug 23 1923

20 UNDERTAKER John H. Deeny ADDRESS 715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78517

D78517

CERTIFICATE OF DEATH.

57

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1926 Orleans ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James F. Douglass

(a) RESIDENCE NO. 1926 Orleans ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Lizzie F. Douglass

6 DATE OF BIRTH (month, day, and year) Mar 1 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	65	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dealer #5

(b) General nature of industry, business, or establishment in which employed (or employer) Butter & Eggs

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER F. Robert Douglass

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Pohle

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Emma A Johnson (Daughter)
(Address) 1926 Orleans St

15 AUG 22 1923, 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1923

17

I HEREBY CERTIFY, That I attended deceased from May 21, 1923, to Aug 20, 1923, that I last saw h.. alive on Aug 20, 1923, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Edward J Levy M. D.

8/24, 1923 (Address) 118 N Irvington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Aug 23 1923

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

Robert P. Harrison, Burial Permit Clerk.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78518

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

179 D78518

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1520 Madeira (St.) 8 WARD)

2-FULL NAME George R. Seubert (Seubert)

(a) RESIDENCE NO. 1520 Madeira ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 22-1883

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	40	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Chester Seubert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosie Imdorf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Marie A. Seubert (Address) 1520 Madeira Ct

15 Filed ..... 19 ..... Registrar

AUG 27 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 1, 1923, to Aug 20, 1923, that I last saw him alive on Aug 20, 1923, and that death occurred, on the date stated above, at 10.20 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. Arena, M. D.

, 19 (Address) 1603 E. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL Aug 23-1923

20 UNDERTAKER John Zellerbach

ADDRESS 2008 Eden

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should sign
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78519

CERTIFICATE OF DEATH.

77

D78519

1-PLACE OF DEATH

REGISTERED No.

CITY OF BALTIMORE: (No. Mt Hope Retreat ST.: 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Cath Horsey

(a) RESIDENCE. No. Berkettsville Md ST., & WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. 0 ds. How long in U. S., if of foreign birth? 48 yrs. 9 mos. 9 da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) September

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Beckettsville
(State or country) Maryland

PARENTS

10 NAME OF FATHER Outerbridge Horsey

11 BIRTHPLACE OF FATHER (city or town) Beckettsville
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Anne Carroll

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mt Hope Retreat
(Address)

15 Filed ....., 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 22 1923

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1923, to August 22, 1923, that I last saw h[illegible] alive on August 22, 1923, and that death occurred, on the date stated above, at 12 ..... m.

The CAUSE OF DEATH* was as follows:

Chronic mania
(Delusion Psychosis)

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Malnutrition - Exhaustion

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Beckettsville, Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wasserman - Physical

(Signed) Milton P. Hall, M. D.

, 19 (Address) Loyola Ave. Pikesville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Weaverton Md	Aug 23 1923

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN)

ADDRESS [illegible]

matter should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78520 D78520

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 16 N Lindsay ave ST., 14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry J. Reed

(a) RESIDENCE No. 164 Lindsay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 8 mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Benjamin L Reed

6 DATE OF BIRTH (month, day, and year) Dec 25 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	8	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) =

(c) Name of employer =

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Patrick J Dempsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Cecelia Moreland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant (Address) Etta L Dempsey 164 Lindsay Ave

15 Filed , 19 Registrar

AUG 21 1923

Robert P. Harrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan , 1921 , to Aug 21 , 1923 .

that I last saw h[illegible] alive on Aug 21 , 1923 ,

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 6 mos da.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 6 hours

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Standish McKelvey, M. D.

(Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral DATE OF BURIAL Aug 23 1923

20 UNDERTAKER F. O. Nuppenau ADDRESS Eutaw Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78521

CERTIFICATE OF DEATH.

124 D78521

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 912 Russell ST., 21 WARD)

2-FULL NAME Minnie Grist.

(a) RESIDENCE NO. 912 Russell ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. 4 mos. 14 ds. How long in U. S., if of foreign birth? ——— yrs. ——— mos. ——— ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (City or town) Baltimore Md

(State or country)

10 NAME OF FATHER John F. Ewal.

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Cecelia Abt

13 BIRTHPLACE OF MOTHER (city or town) Germany

(State or country)

14 Informant (Address) 822 S. Charles St

15 Filed AUG 24 1923, 19.... Robert P. Harrison, Registrar

(Burial Permit Clerk.)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/22/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 8/15/ 1923, to 8/22/ 1923.

that I last saw h~~e~~r alive on 8-22-23, 1923.

And that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Ruptured Gallbladder

probably Gangrene

(duration) yrs. ——— mos. 2 ds.

CONTRIBUTORY (Secondary) Absorption of toxic Material

(duration) yrs. ——— mos. 2 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm Kurd Dunn, M. D.

, 19 (Address) 1727 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL Aug 27 1923

20 UNDERTAKER F. B. Hufford ADDRESS 2136 Eutaw Pl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78522

CERTIFICATE OF DEATH.

100001 D78522

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 26 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William James Clark

(a) RESIDENCE NO. Bay View Asylum ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ? ? 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
about	83			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Municipal Hospital Records.

(Address)

15 Filed ..... By Robert P. Harrison, Registrar

Burial Permit Clerk

AUG 22 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 21 19 23

17 I HEREBY CERTIFY, That I attended deceased from July 12, 19 22, to August 21, 1923, that I last saw him alive on August 20, 1923, and that death occurred, on the date stated above, at 7:05 A.M.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude A Drane, M. D.

8-21-23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. DATE OF BURIAL: Aug 23, 1923

20 UNDERTAKER: Wm Cook ADDRESS: 501 E Monument

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78523

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-001 D78523

1-PLACE OF DEATH Tunnel near R. R. Station Registered No. C.....

City of BALTIMORE: (No. ~~1835~~ at Penna Ave + Wilkens St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Joseph Cross

(Residence in Baltimore: No. 1835 Kavanaugh St.; yrs. 33 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	colored	Married

6-DATE OF BIRTH. August 8 1890
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
33 yrs. mos. ds.	hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... Penna. Rail Road.

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Wm. Cross

11-BIRTHPLACE OF FATHER, (State or Country), Md

12-MAIDEN NAME OF MOTHER, Sarah Collins

13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm. Cross
(Address) 1835 Kavanaugh

15- Filed AUG 23 1923 19.. GLS Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 20, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of skull
Instant death
(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) R. R. accident
(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Aug 22 1923 (Address) 702 Calhoun St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Randall Town, Md.	Aug. 23 1923
20-UNDERTAKER. James A. Dunn	ADDRESS. 302 Gilmor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH PENCIL

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78524

CERTIFICATE OF DEATH.

101-00 D78524

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 Pretman ST., 15 WARD)

2-FULL NAME Joseph Watkins

(a) RESIDENCE No. 1508 Pretman ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ....

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or .....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md. U.S.

PARENTS

10 NAME OF FATHER W. Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md. Kent Co.

12 MAIDEN NAME OF MOTHER Mol Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md. Prince Georges Co.

14 Informant (Address) 1533 n Lucky St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 19, 1923, to Aug 21, 1923

that I last saw him alive on Aug 21, 1923

and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. mos 7 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Paul Brown M. D.

8pr, 1923 (Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Aug 24 23
20 UNDERTAKER James H. Dennis	ADDRESS 1303 Pa Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78525

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D78525

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1332 Stockton ST., 15 WARD)

2-FULL NAME Richard Barnes

(a) RESIDENCE NO. 1332 Stockton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 20 /23

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER James Barnes

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary Davis

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mary Barnes
(Address) 1332 Stockton St

15 Filed ..... 19 ..... Registrar

AUG 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1923, to Aug 22, 1923, that I last saw him alive on Aug 21, 1923 and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) William Fray, M. D.

Aug 23, 1923 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon — DATE OF BURIAL Aug 24 23

20 UNDERTAKER James H. Davis — ADDRESS 1323 Druid Ave

Spec.—1-10-21—M&T—1500 Blks.

D78526 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D78526

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2 Belmarave ST., 26 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME S. Rebecca Comegys

(a) RESIDENCE NO. 2 Belmar ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Leagth of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis B Comegys

6 DATE OF BIRTH (month, day, and year) Oct 27 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 000

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Ind.

PARENTS

10 NAME OF FATHER Henry Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind

12 MAIDEN NAME OF MOTHER Louisa McFarlen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ind

14 Informant agnes F. Madison
(Address) 2 Belmar av

15 Filed AUG 23 1923 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21, 1923.

17 I HEREBY CERTIFY, That I attended deceased from July 1st, 1923, to Aug 21st, 1923.

that I last saw her alive on Aug 21st, 1923.

and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach & Liver

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Gustav A. Seitz, M. D.

1923 (Address) Arcadia

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery — DATE OF BURIAL Aug 23 1923

20 UNDERTAKER J. A. Moran — ADDRESS 300 E Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78527

CERTIFICATE OF DEATH.

100-001 D78527

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2219 Callow Avenue ST., 13 WARD)

2-FULL NAME Joseph Goldberg

(a) RESIDENCE NO. 2219 Callow Avenue ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 22 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frieda Goldberg

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paperhanger

(b) General nature of industry, business, or establishment in which employed (or employer) 52

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Joseph Goldberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary ----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E. Balto. St.,

15 Filed AUG 23 1923 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8 -22- 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 11- , 1923 , to Aug 21- , 1923 ,
that I last saw h— alive on Aug 21 , 1923 ,
and that death occurred, on the date stated above, at 2.50-A. m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis Con Emphysema

(duration) 3 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Broncho - Pneumonia

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) ..... , M. D.

, 19 (Address) 125 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 8/23 1923

20 UNDERTAKER Jack Lewis 1439 E Balto St — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78528

D78528

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 23 N. Patterson Park Ave ST., 6 WARD)

2-FULL NAME Morris Bossin

(a) RESIDENCE NO. 23 N. Pat Park Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Bossin

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	46	—	—	

8 OCCUPATION OF DECEASED 045

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Moving Picture

(c) Name of employer Parlor

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Bossin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Liba Gumpler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E Balt St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/22 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 14th, 1923, to Aug. 22nd, 1923,

that I last saw him alive on Aug. 22nd, 1923,

and that death occurred, on the date stated above, at 3:45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Miliary Tuberculosis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical & laboratory

(Signed) Harry E. Levit M. D.

Aug 23rd 1923 (Address) 2221 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 8/23 1923

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Simonsen)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78529 D78529

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 Holtzman Ct ST. 1 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna C. Simonsen

(a) RESIDENCE NO. 522 Holtzman Ct ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ... yrs. 8 mos. 18 ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		8	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Arthur H. Simonsen

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Auffarth

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs. Eliz. Simonsen
(Address) 522 Holtzman Ct

15 Filed AUG 23 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1923, to Aug 22, 1923,
that I last saw her alive on Aug 22, 1923
and that death occurred, on the date stated above, at 5½ a m.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ... yrs. ... mos. 2 ds.
CONTRIBUTORY (Secondary) Whooping Cough
(duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Typical signs

(Signed) C. S. Neer, M. D.
8/24/23 (Address) 408 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cem	Aug 23 1923
20 UNDERTAKER Fred'k W Ozazuski	ADDRESS 1950 Eastern ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

MARGIN RESERVED FOR BINDING

HEALTH DEPARTMENT—CITY OF BALTIMORE

1855

D58530

CERTIFICATE OF DEATH.

Registered No. D58530

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph Hospital Ward) 18

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Lucy J. Slattsbuck

(Residence in Baltimore: No. 103 Scott st St.; yrs. 57 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE. white

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. June 15th (Month) (Day) 1[illegible] (Year)

7-AGE. 52 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. house work
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER. Dixie Wakenight

11-BIRTHPLACE OF FATHER, (State or Country). Va

12-MAIDEN NAME OF MOTHER. Carrie Vineyard

13-BIRTHPLACE OF MOTHER, (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Jos W Slattsbuck

(Address) 103 Scott Street

15-

Filed AUG 23 1923 19[illegible] G G Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 21st (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH was as follows:

Fracture of skull
due to falling down
steps Accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner.)

Aug 23 1923 (Address) 2612 Boulevard

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. MOUNT ABLE MEMORIAL CHAPEL CEM HARRISONBURG, VA.

DATE OF BURIAL. Aug 24th 1923

20-UNDERTAKER. John F Bowman & Son Per J F Bowman

ADDRESS 900 East Lombard St South Eastern R.R.

Spec.—1-10-21—M&T—1500 Bks.

165609. (Bohachovich)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78531 — 113 D78531

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. (") (") (")

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " ") ST. 19 WARD)

2-FULL NAME George Bohachovich City.

(a) RESIDENCE No. 1316 Mc Henry St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Pete (father).

6 DATE OF BIRTH (month, day, and year) Jan. 12, 1923.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
—	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child. NO

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Pete Bohachovich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Serbia

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL.

15 Filed AUG 23 1923 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21, 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 7, 1923. to Aug 21, 1923. that I last saw him alive on Aug 21, 1923. and that death occurred, on the date stated above, at 1.20 P. m.

The CAUSE OF DEATH* was as follows:

Vomiting and diarrhoea (not dysentery)

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (terminal)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Mt. Wilson Sanitarium.

Did an operation precede death? No Date of —

Was there an autopsy? Yes X

What test confirmed diagnosis?

(Signed) A. A. Weech M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Aug 23 19

20 UNDERTAKER A Jones — ADDRESS N. & E.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every letter and figure should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Charles Hampton)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78532

CERTIFICATE OF DEATH.

32 ✓ D78532

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1315 Lafayette Ave WARD)

2-FULL NAME Chas. Hampton

(a) RESIDENCE NO. 1315 Lafayette Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Evelyn Hampton

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ordinary

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Hannah Tennant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Carolina

14 Informant Evelyn Hampton (Address) 1360 Lafayette Ave

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21st 1923

17 I HEREBY CERTIFY, That I attended deceased from July 12th 1923 to Aug 21st 1923. that I last saw h alive on Aug 20th 1923 and that death occurred, on the date stated above, at 12.40 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) A Lee Hiss M. D.

1923 (Address) 924 Mott Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn C

DATE OF BURIAL Aug 24 23

20 UNDERTAKER J L Brown & Son

ADDRESS 1088 W Montg. St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Irene Lawrence

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78533

CERTIFICATE OF DEATH.

38

D78533

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 120 Dover ST., 22 WARD)

2-FULL NAME. Irene Lawrence

(a) RESIDENCE NO. 120 Dover ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 4 - 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Mattie Lawrence

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Jennie Sutton
(Address) 120 Dover St

15 Filed AUG 23 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/23/1923

17 I HEREBY CERTIFY, That I attended deceased from 8/21, 1923, to 8/23, 1923,
that I last saw h[illegible]ative on 8/22, 1923,
and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis
(duration) yrs. 3 mos ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stephen Owen M. D.

, 19 (Address) 509 Mosher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Ct	Aug 24 1923
20 UNDERTAKER	ADDRESS
C. V. Brown & Son	1818 Mount St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., *of*..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Lustic

D78534

HEALTH DEPARTMENT—CITY OF BALTIMORE (Puntha) ✓

74-001 D78534

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1939 Druid Hill Ave, St. 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Joseph Puntha

(Residence in Baltimore: No. 1939 Druid Hill Ave, St.; yrs. 40 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) married

6-DATE OF BIRTH. about 1869
(Month) (Day) (Year)

7-AGE. 54 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Insurance Agent
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER, Lydia A. Swallow

13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James E. Ebbs.

(Address) 511 W. Calhoun St.

15-

Filed AUG 23 1923 19.. G G Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 21 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. E. Hennessy, M. D.
(Coroner.)

Aug 22, 1923 (Address) 2102 Eutaw Pl

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
St Peters Cem.	Aug 24 1923
20-UNDERTAKER,	ADDRESS
Joseph A Purnell	2318 Madison

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D78535 HEALTH DEPARTMENT—CITY OF BALTIMORE D78535

CERTIFICATE OF DEATH. X 179

1-PLACE OF DEATH Registered No. C.....

City of BALTIMORE: (No. Hospital St. 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Foster

(Residence in Baltimore: No. 17 W. Lorder St.; yrs., (2) mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY. WITH PEN AND INK.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: Colored

5-Single, Married, Widowed or Divorced, (Write the word.): Single

6-DATE OF BIRTH: Oct 31 (Month) (Day) 1879 (Year)

7-AGE: 26 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundry Hand
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country): S C

PARENTS.

10-NAME OF FATHER: Alfred Martin

11-BIRTHPLACE OF FATHER, (State or Country): S C

12-MAIDEN NAME OF MOTHER: Ester Hall

13-BIRTHPLACE OF MOTHER, (State or Country): S C

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mernira Foster

(Address) 17 W. Lorder St

15- Filed AUG 23 1923 192 H. A. Mc Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 21 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd Burns from Boiler explosion accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Thomson M. D. (Coroner.)

Aug 24 1923 (Address) 1512 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Wilson Creek, Iva, S C — DATE OF BURIAL: [redacted] 23 1923

20-UNDERTAKER: J. G. Brown & Son — ADDRESS: 108 W. Montgomery

Route, P.R.R. Southern R.R. to Cal. & C.R.R. to Iva S C

Spec.—1-10-21—M&T—1500 Blks.

D78536

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78536

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4 Prospect Circle ST. 15 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emanuel Edward Teale

(a) RESIDENCE No. 4 Prospect Circle ST. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Malvina O. Teale

6 DATE OF BIRTH (month, day, and year) May 15-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt. 069

(b) General nature of industry, business, or establishment in which employed (or employer) Office Bldg.

(c) Name of employer Property Leasing Co

9 BIRTHPLACE (city or town) (State or country) Brooklyn N.Y.

PARENTS

10 NAME OF FATHER John P. Teale

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Margaret Garthright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs Olive F. Bell

(Address) Prospect Circle

15 Filed AUG 23 1923 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1 1923 to Aug 21 1923, that I last saw him alive on Aug 21 1923, and that death occurred, on the date stated above, at 3.35 A m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? –

Did an operation precede death? – Date of

Was there an autopsy? –

What test confirmed diagnosis? –

(Signed) Ernest Dr. Kalm M. D.

8/23 1923 (Address) 910 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Aug 24 1923

20 UNDERTAKER Wm J. Tickner & Sons ADDRESS W. Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78537

CERTIFICATE OF DEATH.

161-002

D78537

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Black

(a) RESIDENCE NO. 1141 Brenner ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 15-1923.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
0	0	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Earl Woody

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Beatrice Black

13 BIRTHPLACE OF MOTHER (city or town) Raleigh
(State or country) N.C.

14 Informant W. W. Gray
(Address) Johns Hopkins Hospital.

15 Filed AUG 23 1923 G G Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 20 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1923. to Aug 20. 1923.

that I last saw h[illegible] alive on Aug 20. 1923.

and that death occurred, on the date stated above, at 7-00 P. m.

The CAUSE OF DEATH* was as follows:

Intra cranial hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) W. W. Gray, M. D.

..... 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	AUG 22 1923

20 UNDERTAKER ..... ADDRESS .....

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

160

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Birth Injury

Spec.—1-10-21—M&T—1500 Bks.

165664 D78538

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 D78538

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. ..... ST. 12 WARD)

2-FULL NAME Ruth Hepbron.

(a) RESIDENCE NO. 339 E. 28th St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White.

5 Single, Married, Widowed, or Divorced. (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 31, 1923

7 AGE Years ..... Months ..... Days 23 If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby (2d)

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER James Hepbron.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Grace Carneck.

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed AUG 23 1923 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1923, to Aug 23, 1923, that I last saw her alive on Aug 23, 1923 and that death occurred, on the date stated above, at 4.20 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity.
(duration) 0 yrs. 0 mos 23 ds.

CONTRIBUTORY (Secondary) Prematurity
(duration) 0 yrs. 0 mos. 23 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical histories and physical examination

(Signed) William H. F. Wartha M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Balto Cem. DATE OF BURIAL 8/23 1923

20 UNDERTAKER Philip Henrig ADDRESS 2016 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78539

CERTIFICATE OF DEATH.

57 D78539

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Coster

(a) RESIDENCE NO. HayView Hospital. ST., ... WARD ...
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 50 yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Peter Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Jennings

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Municipal Hospital Records. (Address)

15 Filed ... 19 ... Registrar

AUG 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 21 19 23

17

I HEREBY CERTIFY, That I attended deceased from August 9 19 23, to August 21, 19 23,

that I last saw her alive on August 21, 19 23

and that death occurred, on the date stated above, at 9:10 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ... yrs. ... mos 2 ... ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Wm. J. Fulton M. D.

8-22-23 19 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Aug 24, 23
20 UNDERTAKER	ADDRESS
Jas C. Miller	2338 Jefferson St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78540 ✓ D78540

CERTIFICATE OF DEATH.

129 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 937 Duncan ST., 7 WARD)

2-FULL NAME Anna E. Scott.

(a) RESIDENCE NO. 937 Duncan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~ Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Wife of Richard F. Scott.

6 DATE OF BIRTH (month, day, and year): May 18-1860

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
63	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Ross.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Anna Scott. (Address): 937 Duncan.

15 Filed AUG 23 1923, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 22 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1923, to Aug 22, 1923, that I last saw her alive on Aug 21, 1923, and that death occurred, on the date stated above, at 3.a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Tuberculosis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis (duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy? None

What test confirmed diagnosis?

(Signed) N. Bastuscu M. D.

19 (Address) 2927 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County — DATE OF BURIAL: Aug 25th 23

20 UNDERTAKER: Jas E. Miller — ADDRESS: 2334 Jeffers St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

KODAK S·A

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question must be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78541

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 D78541

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3 Spring Ave (West) ST., 27 WARD)

2-FULL NAME Virginia Kay Blake

(a) RESIDENCE No. 3 West Spring Ave., Roseberg ST., 27 WARD
(Usual place of abode)
Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mch. 28, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	6	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Lot
(State or country) Virginia

PARENTS

10 NAME OF FATHER Geo. H. Blake

11 BIRTHPLACE OF FATHER (city or town) Lot.
(State or country) Va.

12 MAIDEN NAME OF MOTHER Marie B. Webster

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Mrs Geo. H. Blake
(Address) 3 Spring Ave. West.

15 Filed AUG 23 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23, 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923, to Aug 23, 1923, that I last saw her alive on Aug. 22, 1923, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Epileptiform Convulsions

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Congenital Idiocy

(duration) 6 yrs. mos ds.

18 Where was disease contracted if not at place of death?...

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Wilkinson, M. D.

8-23-1923 (Address) 13 Bel Air Rd., Roseberg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: Aug 25 1923

20 UNDERTAKER: Frederick Lassahn & Sons — ADDRESS: Fullerton

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78542

CERTIFICATE OF DEATH.

4f D78542

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 377 E 77nd St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry L Brooke

(a) RESIDENCE No. 377 E 77nd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M. 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta D Brooke

6 DATE OF BIRTH (month, day, and year) — — 85 V

7 AGE Years 71 Months — Days — If LESS than 1 day, ...hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Deputy Sheriff

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City of Balto

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edw Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Fitzgerald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant H. B. Shipman (Address) 377 E 77nd St.

15 Filed ..... . 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 1 . 1923. to Aug 21st . 1923.

that I last saw him alive on Aug 21st . 1923.

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Probable - Malignant growth over

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald J Tonry M. D.

. 19 (Address) 4142 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL 8/24 1923

20 UNDERTAKER J. F. Talbert & Sons

ADDRESS 1318 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Stomach

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78543

CERTIFICATE OF DEATH.

90 D78543

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2134 E. Federal ST., 8 WARD)

2-FULL NAME Louis W Yenoch

(a) RESIDENCE NO. 2134 E. Federal ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Pauline B Yenoch

6 DATE OF BIRTH (month, day, and year) Aug 21 1899

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24	—	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist. Asm 031

(b) General nature of industry, business, or establishment in which employed (or employer) Hammer + Piston Corp

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Chas J Yenoch

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Louisa Spengler

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mr Chas J Yenoch
(Address) 2134 E Federal st

15 Filed ..... 19 ..... Registrar

AUG 23 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 21 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1 19 23 to Aug 21 19 23

that I last saw h alive on Aug 20 19 23

and that death occurred, on the date stated above, at 5 30 a m.

The CAUSE OF DEATH* was as follows:

acute Nephritis (cause unknown)
Hypertension Mitral
Regurgitation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Aunt Edna Yenoch

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Pending

(Signed) F Fred Bayliss M. D.

19 (Address) 600 N Matt Okk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 24 1923
20 UNDERTAKER John F. Denny	ADDRESS 715 Light

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001 D78544

D78544

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (a) No. 3668 Falls Road ST., 13 WARD)

2-FULL NAME Oliver N. Ruby

(a) RESIDENCE No. 3668 Falls Road ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen M. Ruby

6 DATE OF BIRTH (month, day, and year) Sept. 22-1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Assistant Supt. 886

(b) General nature of industry, business, or establishment in which employed (or employer) Republic Radiator Co

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co

(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel Ruby

11 BIRTHPLACE OF FATHER (city or town) Carroll Co.

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Amanda Snyder

13 BIRTHPLACE OF MOTHER (city or town) Carroll Co

(State or country) Maryland

14 Informant Mrs. Helen M. Ruby

(Address) 3668 Falls Road

15 Filed AUG 23 1923, 19 ... Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1923

17

I HEREBY CERTIFY, That I attended deceased from July 16th, 1923, to Aug 23, 1923, that I last saw him alive on Aug 22nd, 1923, and that death occurred, on the date stated above, at 1.45 A. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever.

(duration) yrs. mos 38 ds.

CONTRIBUTORY (Secondary) ...

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J. [illegible] M. D.

Aug 23, 1923 (Address) 846 W 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL Aug 25 1923.

20 UNDERTAKER Horace H. Burgee — ADDRESS 363 Fallsd.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78545 ✓ 129 D78545

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1512 N Franklin ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank L Day

(a) RESIDENCE NO. 1512 N Franklin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leona C Day

6 DATE OF BIRTH (month, day, and year) June 5 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	54	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Frederick Co Maryland

PARENTS

10 NAME OF FATHER Madison L Day

11 BIRTHPLACE OF FATHER (city or town) (State or country) Montgomery Co Maryland

12 MAIDEN NAME OF MOTHER Jannie E Miles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Montgomery Co Maryland

14 Informant Leona C Day

(Address) 1512 N Franklin St

15 Filed AUG 23 1923 , 19 Robert P. Garrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 10, 1923 to Aug 22, 1923

that I last saw h alive on Aug 22, 1923

and that death occurred, on the date stated above, at 11 05 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Indefinite

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremic Convulsions

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R B Campbell M. D.

Aug 23 1923 (Address) 1604 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem — DATE OF BURIAL Aug 24 1923

20 UNDERTAKER Joseph B. Cook — ADDRESS 1003 N. Ballo St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(James Blake)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78546

CERTIFICATE OF DEATH.

100-001 D78546

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 750 Sarah Ann ST., 4th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Blake

(a) RESIDENCE NO. 750 Sarah Ann ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel Blake

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant Rachel Blake
(Address) 750 Sarah Ann St.

15 Filed AUG 24 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/20 1923

17 I HEREBY CERTIFY, That I attended deceased from 8/18 1923 to 8/20 1923, that I last saw him alive on 8/20 1923, and that death occurred, on the date stated above, at 8 p. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) T. L. Jackson, M. D.

, 19 (Address) 767 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	Aug. 24 1923
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78547 — 31 ✓ — D78547

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tubercular Hosp., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Williams

(a) Residence No. 1023 Park Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mrs. James Williams

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 50 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel

(c) Name of employer Hotel Rennert

9-BIRTHPLACE (city or town) (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. Arch Williams

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Mary Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va.

14- (Informant) James Williams

(Address) 1023 Park Ave.

15- AUG 24 1923 19 GG Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-21-23

17- I HEREBY CERTIFY, That I attended deceased from Aug 4 1923, to Aug 21 1923, that I last saw h im alive on Aug 21 1923, and that death occurred, on the date stated above, at 8-30 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) No.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Sputum, X-ray

(Signed) L. A. Lally M. D.

19 (Address) Municipal Tb. Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Takhannock Wyl — DATE OF BURIAL. Aug 24 1923

20-UNDERTAKER, Essex Co. — ADDRESS 142 Hartford St

John H. Toudvine

N. B—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(William Opy) ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78548

101-00 D78548

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1037 N. Carey St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... William Opy

(a) Residence No. 1037 N. Carey St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Nancy Opy

6-DATE OF BIRTH (month, day and year) June 1878

7-AGE.	If LESS than 1 day.
45 yrs. ..... mos. ..... ds.	....hrs. or.....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country). Virginia

PARENTS.

10-NAME OF FATHER. C Opy

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country). Va

12-MAIDEN NAME OF MOTHER. Sidonia Blackwell

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country). Va

14- (Informant)..... Nancy Opy

(Address)..... 1037 N. Carey St

15-

Filed....., 19?..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 22 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug 7, 1923, to Aug 22, 1923, that I last saw h[illegible] alive on Aug 21, 1923, and that death occurred, on the date stated above, at 4.45 m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(Duration)..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Va Railway Co

(Duration)..... yrs. ..... mos. 14 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? N.A. Date of (.....)

Was there an autopsy? N.A.

What test confirmed diagnosis? Observation & Symptoms

(Signed) C. F. Green, M. D.

(Address) 712 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	Aug 24 1923
20-UNDERTAKER.	ADDRESS 142
John H. Toadvine	Ostend St

I. B. [illegible] should be carefully supplied. AGE should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates.

Cause of death stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78549 — CERTIFICATE OF DEATH. — 32 — D78549

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3005 Tait Ave St. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Klehm.

(a) RESIDENCE NO. 3005 Tait Ave St. 3 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline Klehm

6 DATE OF BIRTH (month, day, and year) April 11-1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Adam Klehm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Klehm (Address) 3005 Tait Ave.

15 Filed AUG 24 1923 19 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1923

17

I HEREBY CERTIFY, That I attended deceased from Feb 8, 1923, to Aug 22, 1923.

that I last saw h[illegible] alive on Aug 21, 1923.

and that death occurred, on the date stated above, at 12 45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Tuberculosis ?

(duration) yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? By general signs

(Signed) [signature] M. D.

, 19 24 (Address) 3325 Pattapsco Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 24 1923

20 UNDERTAKER H. Sander & Sons ADDRESS 1710 Fleet St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78550 HEALTH DEPARTMENT—CITY OF BALTIMORE 001

14 D78550

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sa Sarto Gen Hosp ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Antonina Miskowitz (Miskowicz)

(a) RESIDENCE NO. 1623 Shakespeare St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ walter miskowitz

6 DATE OF BIRTH (month, day, and year) 6/15/1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Peter Matyskiel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wladyslaw Miskiewicz

(Address) 1623 Shakespeare St

15 Filed ..... 19 ..... Registrar

AUG 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 22 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 19, 1923 to Aug 22, 1923

that I last saw her alive on Aug 22, 1923,

and that death occurred, on the date stated above, at 1145A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Apoplexy

20 days (duration) yrs. 1 mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H C Warlick, M. D.

8-22 1923 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL 8/25 1923

20 UNDERTAKER William Fialkowski

ADDRESS 168 Eastern Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of Certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

078551 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-00/078551

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 422 S Bond St., 3 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Margolis

(a) Residence No. 4225 Bond St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE. 75 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town)..... (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Morris Guinson

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Russia

14- (Informant) L Margolis

(Address) 4225 Bond St

15-

Filed AUG 24 1923 19.. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/24/23

17- I HEREBY CERTIFY, That I attended deceased from July 19.22 to Aug 23 19.23

that I last saw h.. alive on Aug 23 19.23

and that death occurred, on the date stated above, at 3a m.

The CAUSE OF DEATH* was as follows:

Cerebral arteriosclerosis

hypertension chronic

interstitial nephritis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S S Mitchelson M. D.

8/23. 1923 (Address) 2230 Eutaw Place

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Sinai Rosedale DATE OF BURIAL. 8/25 19.23

20-UNDERTAKER. S. Guinson & Bro ADDRESS 1127 E Balto St

N. B.—WHITE PENCIL should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78552 D78552

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 Latrobe St. ST.; 12 WARD)

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Hall

(Residence in Baltimore: No. 1718 Latrobe St St.; 11 yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

~~SINGLE~~, MARRIED, ~~WIDOWED~~, ~~OR DIVORCED~~, (Write the word.) Married

6-DATE OF BIRTH, December 23, 1862 (Month) (Day) (Year)

7-AGE, 60 yrs. 8 mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md

PARENTS.

10-NAME OF FATHER, Wm Hall

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Hall

(Address) 1718 Latrobe St

15-

Filed AUG 24 1923, 191

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 23rd (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 16th 1923, to Aug 22 1923, that I saw h[illegible] alive on Aug 23rd 1923, and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Ex Lues ?

(Duration) yrs. mos. ds.

(Signed) Wm M. Wright M. D.

Aug 23 1923 (Address) 180 St Paul St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Laurel Cemetery

DATE OF BURIAL. Aug 24, 1923

20-UNDERTAKER George W. Gibson

ADDRESS 613 Laurens

Spec.—1-10-21—M&T—1500 Bks.

D78553 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 D78553

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3102 Remington Ave ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J. Thompson

(a) RESIDENCE No. 3102 Remington Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Anna K. Thompson

6 DATE OF BIRTH (month, day, and year) Jan 26 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Morris Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Priscilla Sling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Anna K Thompson (Address) 3102 Remington Ave

15 Filed ..... 19 ..... Registrar

AUG 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1923

17 I HEREBY CERTIFY, That I attended deceased from July 21 1923 to Aug 22 1923.

that I last saw him alive on Aug 22 1923

and that death occurred, on the date stated above, at 1P m.

The CAUSE OF DEATH* was as follows:

Ethanism

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary) Carcinoma

Liver (duration) yrs. 18 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept 20. 23

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) L A Riddon M. D.

Aug 24 1923 (Address) 113 W 25 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's - Hagerstown	Aug 25 23

20 UNDERTAKER A S Marshall ADDRESS 3539 Lib Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DATA entered thereon should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78554

CERTIFICATE OF DEATH.

129

D78554

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1001 Woodley ST.: 16 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Louisa A. Hollyfield

(a) RESIDENCE. No. 1001 Woodley ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs about mos. ds. How long in U. S., if of foreign birth? 55 yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow.

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Frederick H. Hollyfield

6 DATE OF BIRTH (month, day, and year) May 23. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocer. 03

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Germany Ins & about 55 yrs

PARENTS

10 NAME OF FATHER: Carl Wilhelm Kelch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: George E. Shannon
(Address): 700 Fulton Ave

15 Filed AUG 24 1923 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23. 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1923, to Aug 23, 1923, that I last saw her alive on Aug 22, 1923, and that death occurred, on the date stated above, at Dennis m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation (duration) yrs. ✓ mos. short ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) 2 yrs. ✓ mos. ✓ ds.

18 Where was disease contracted if not at place of death? Usual

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Usual

(Signed) George E Shannon, M. D.

8/23, 1923 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 25/23

20 UNDERTAKER: Geo. Weber Son ADDRESS 2503 Edmondson ave

N. B.—WRITE PLAINLY. WITH UNFADING INK. PHYSICIANS should be stated EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78555

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-00 D78555

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3353 Fredericks ST.: 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. O'Keefe

(a) RESIDENCE. NO. 3353 Fredericks ST. 20 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mamie A. Keefe

6 DATE OF BIRTH (month, day, and year) June 19 1865

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
57	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher Man

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jno A. Keefe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Edwin R. Laurence
(Address) 3353 Fredericks

15 Filed AUG 24 1923 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1923, to Aug 24, 1923, that I last saw h[illegible] alive on Aug 24, 1923, and that death occurred, on the date stated above, at 7.20 p. m.

The CAUSE OF DEATH* was as follows:

Rt. sided Hemiplegia-Chronic nephritis and Sclerosis; Hypertrophied heart with Arterio Sclerosis (duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation with Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No 3353 Fredericks

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Daniel P. Clayton M. D.

, 19 (Address) 3376 Fredericks

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 25 1923
20 UNDERTAKER C. W. Dill	ADDRESS 3109 Frederick Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE MUST BE FILLED OUT EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Leonard

Spec—12-23-21—E.B.R.S.—400 Bks.

D78556

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78556

CERTIFICATE OF DEATH.

113

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 702 Melrose Alley St. 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Henry Cockrell

(a) Residence No. 702 Melrose alley Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 27-22

7-AGE.	If LESS than 1 day.
....yrs. 6 mos. ....ds.	....hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer)..... 1

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Ernest Cockrell

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Alice Gaskins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Virginia

14- (Informant) Fowler Cockrell

(Address) 702 Melrose Alley

15-

Filed ..... 192.....

AUG 24 1923

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) aug 22 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug. 10 1923 to Aug. 22 1923

that I last saw h.im alive on Aug 22 1923

and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Gastro - Enteritis

Otitis Media

Indefinite (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

.....(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis?.....

(Signed) Harry Glassman M. D.

Aug 23 1923 (Address) 2682 Monument ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Dist Woodlawn Cem	Aug 24 1923
20-UNDERTAKER.	ADDRESS
David Easter	716 Pratt

N. B.—WRITE PLAINLY. Words should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.—400 Bks.

(Lena Boucher)

D78557

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78557

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Sisters of the Poor, St., 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lena Boucher

(a) Residence No. Preston & Valley Sts. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female.

4-COLOR OR RACE, White

5-~~Single,~~ Married, Widowed, ~~or Divorced,~~ (Write the word.)

5a-If married, widowed, ~~or divorced~~ ~~HUSBAND~~ of (or) ~~WIFE~~ of Jacob Boucher.

6-DATE OF BIRTH (month, day and year) 25 Oct 1845.

7-AGE. 77 yrs. 9 mos. 28 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, George Durlage.

11-BIRTHPLACE OF FATHER (city or town) (State or Country).

12-MAIDEN NAME OF MOTHER, —

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), —

14-

(Informant) Sister Florence

(Address) Preston & Valley

15-

Filed AUG 24 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 23/23

17- I HEREBY CERTIFY, That I attended deceased from to record 19 to 19

that I last saw h.. alive on Aug 19 1923

and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Valvular Disease of heart

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dropsy

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Aug 23, 1923 (Signed) F. A. Warner, M. D (Address) 1133 Valley St.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Sacred Heart DATE OF BURIAL. Aug 25, 1923

20-UNDERTAKER. K. C. Wiedefeld ADDRESS 914 Greenmount Av

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78558

CERTIFICATE OF DEATH.

109-002 D78558

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2430 Lanetta Ave ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A Lang Jun.

(a) RESIDENCE. NO. 2430 Lanetta ST.. WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 30-1907.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 009

(b) General nature of industry, business, or establishment in which employed (or employer) Fidelity Trust Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md.

PARENTS

10 NAME OF FATHER John J. Lang.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. md.

12 MAIDEN NAME OF MOTHER Carrie Breitenbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. md.

14 Informant John J. Lang. (Address) 2430 Lanetta Ave.

15 Filed AUG 24 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 21 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1 1923 to Aug 24 1923 that I last saw h[illegible] alive on Aug 20 1923 and that death occurred, on the date stated above, at 6.45 a. m.

The CAUSE OF DEATH* was as follows:

Acute Jaundice
Acute Endocarditis
Hypochondritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Finding

(Signed) J. Fred Rupp Jr. M. D.

8-23-23 (Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	Aug 25 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

165794 D78559

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 ✓ D78559

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 26 WARD)

2-FULL NAME Robert Madsen.

(a) RESIDENCE NO. 3326 Foster Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
		3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Hugh Madsen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Carolyn Zeller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed AUG 24 1923 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 16, 1923, to Aug. 23, 1923, that I last saw him alive on Aug. 23, 1923, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Abscess of chest wall (duration) 0 yrs. 0 mos 9 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of Aug. 17, 23

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) William H. Watthews, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL Aug 25 1923

20 UNDERTAKER Lilly and Zeiler. ADDRESS 403 S. Wolfe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78560

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78560

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1507 N. Monroe ST.) 15 WARD)

2-FULL NAME George W. Norris

(a) RESIDENCE. No. 1507 N. Monroe ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced BUSBAND of (or) WIFE of Jerusha M. Norris

6 DATE OF BIRTH (month, day, and year) July 15 - 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo. Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs. Jerusha M. Norris 1507 N. Monroe

15 Filed ... 19 ... Registrar

AUG 24 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1923

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1920, to Aug 24, 1923, that I last saw h pm alive on Aug 24, 1923, and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

About (duration) 4 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Complications

(duration) - yrs. - mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urinary.

(Signed) Chas. C. Conser, M. D.

8/24, 1923 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	Aug 27 1923
20 UNDERTAKER Geo. W. Little	ADDRESS Edmondson Ave

B—WRITE PLAINLY. Ink should be used. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78561 ✓ HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78561

CERTIFICATE OF DEATH. X 84

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Prichard

(a) RESIDENCE NO. Mannington, ST. W. Va WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 16 mos. 14 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Arthur L.

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Kate Humberlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ky.

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed AUG 24 1923, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24 1923

17

I HEREBY CERTIFY, That I attended deceased from July 10, 1923, to Aug 24, 1923,

that I last saw h alive on Aug 24, 1923,

and that death occurred, on the date stated above, at 1.50 p m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? W. Va

Did an operation precede death? Yes Date of Aug 22-23

Was there an autopsy? Yes

What test confirmed diagnosis? Path. exam

(Signed) Warfield M Theobald, M. D.

8/24 1923 (Address) 704 Lt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mannington W Va	Aug 24 1923
20 UNDERTAKER	ADDRESS
Joseph Ahrens	221 B Way

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Mascherone

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78562

CERTIFICATE OF DEATH.

113 D78562

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 437 E. 27th St., 12 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME alfred Mascherone

(a) RESIDENCE NO. 437 E. 27th St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
m	W	S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of child.

6 DATE OF BIRTH (month, day, and year) 4/15/1923.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Fred. Mascherone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Anna Mennano

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Fred. Mascherone

(Address) 437 - E. 27th St

Filed AUG 24 1923

Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/24/1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 23, 1923, to Aug 24, 1923.

that I last saw h~~e~~live on Aug 24, 1923

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Enterocolitis

acute

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G. C. Jones, M. D.

(Address) 30 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Sepulchre DATE OF BURIAL 8-25-23.

20 UNDERTAKER Geo. J. Potts ADDRESS 1235 Harford Ave

WRITE PLAINLY, WITH UNFADING INK. THE ENTIRE INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Louise Steinman

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78563

CERTIFICATE OF DEATH.

188-0078563

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hospital ST., 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louise Hermann

(a) RESIDENCE No. 1821 N Mulberry ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 26 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	5	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore City
(State or country)

PARENTS

10 NAME OF FATHER Christian Hermann

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Schultz

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Charles Weaver
(Address) 3019 Windsor Ave

15 Filed AUG 24 1923, 192 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23. 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull.

(duration) ..... yrs. ..... mos. 3 hrs

CONTRIBUTORY (Secondary) Shock following or rel.

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

Aug 24 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Aug 25 1923

20 UNDERTAKER Mr. & Mrs. J. W. Teufel & Son ADDRESS 801 N. Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UG 24 1923

Spec.—1-10-21—M&T—1500 Bks.

D78564

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78564

38

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 Curtis Ave ST., 25 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johanna Pierman

(a) RESIDENCE NO. 1401 Curtis Ave ST., 25 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of: George E. Pierman

6 DATE OF BIRTH (month, day, and year): Feb. 20, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Robert Wright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Martha J. Franklin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address): William B. Mitchell 1401 Curtis Ave.

15 Filed AUG 24 1923, 19.. Robert P. Harrison Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 22 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 20, 1923, to Aug 22, 1923.

that I last saw her alive on Aug 21, 1923

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Aneurism

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Cystitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fenn L. Harlow, M. D.

Aug 23 1923 (Address) Curtis Bay, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Aug 25 1923

20 UNDERTAKER: Margaret G. Flynn — ADDRESS: 1402 Light St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

D78565

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74400 D78565

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 S Smallwood St., 20 WARD)

2-FULL NAME Lydia E Carey

(a) RESIDENCE NO. 416 S Smallwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph B Carey

6 DATE OF BIRTH (month, day, and year) Dec 22 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) A A Co

(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Carey

11 BIRTHPLACE OF FATHER (city or town) A A Co

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Merritt

13 BIRTHPLACE OF MOTHER (city or town) A A Co

(State or country) Maryland

14 Informant Mrs Jessie Smith

(Address) 416 S Smallwood St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 22 1923

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1923, to Aug 22, 1923, that I last saw her alive on August 21, 1923, and that death occurred, on the date stated above, at 10 45 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Apoplexy)

(duration) yrs. mos 2 hrs ds

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M A Smith M. D.

8/24, 1923 (Address) 708 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 25 1923
UNDERTAKER Joseph B. Cook	ADDRESS 1003 W Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE may be properly classified. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78566 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 ✓ D78566

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 720 S. Bethel ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha P. Bupczyk.

(a) RESIDENCE NO. 720 S. Bethel ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 26-1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Baltimore.
(State or country)

PARENTS

10 NAME OF FATHER Frank.

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Mary. Iowaszeng.

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Mary Bupczyk
(Address) 720 S. Edwards

15 Filed AUG 25 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug. 25, 1923, to Aug. 25, 1923, that I last saw her alive on Aug. 25, 1923, and that death occurred, on the date stated above, at 8 30 a. m.

The CAUSE OF DEATH* was as follows:

Meningitis (Cerebral)

(duration) yrs. mos. 1 da.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? /

(Signed) John H. Kehlberger M. D.

, 19 (Address) 1709 Aliceanna St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL 8/25 1923

UNDERTAKER Mrs. Fraelsworth

ADDRESS 1618 Eastern

N. B.—WRITE PLAINLY, WITH CAPACITY AND INK. PHYSICIANS should state exactly. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Simple

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78567

CERTIFICATE OF DEATH.

38 D78567

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto Liberty Sts ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas S. Carey

(a) RESIDENCE NO. 428 Hutchinson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 15 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	2	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Porter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Bath Bazaar House

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER James H Carey

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Nancy Bryant

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Margery Carey
(Address) 428 Hutchinson Ave

15 Filed AUG 25 1923 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8, 23, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. a few mos. ds.

CONTRIBUTORY (Secondary) Dorit Knott

(duration) yrs. mos. ds.

(Signed) A R Gorsuch M. D.
(Coroner)

8 24, 1923 (Address) 111 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Remington DATE OF BURIAL Aug 27 1923

20 UNDERTAKER Samuel Moseley ADDRESS Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D78568

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78568

CERTIFICATE OF DEATH.

179

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 17 WARD)

2-FULL NAME Annie V. Smith Johnson

(a) RESIDENCE NO. 1321 Argyle Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-3-1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62		20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) Washington D C
(State or country)

PARENTS

10 NAME OF FATHER John M Stewart

11 BIRTHPLACE OF FATHER (city or town) Washington D C
(State or country)

12 MAIDEN NAME OF MOTHER Sarah E Stewart

13 BIRTHPLACE OF MOTHER (city or town) Washington DC
(State or country)

14 Informant Carrie M Smith
(Address) 1321 Argyle

15 Filed ....., 192 .....

AUG 25 1923

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-23, 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... find that said deceased came to ~~his~~ her death on the day stated above.
(Inquest, autopsy or inquiry.)

The CAUSE OF DEATH* was as follows:

Severe bruises on body & chest

(duration) ... yrs. ... mos. ...

CONTRIBUTORY (Secondary) Clothing accidentally caught fire from open grate

(duration) ... yrs. ... mos. ... ds.

(Signed) ..... M. D.
(Coroner.)

8/23 1923 (Address) 111 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL Aug 25 23

20 UNDERTAKER Sarah E Hemsley

ADDRESS 1 E Lexington St

BURIAL SHOULD BE CAREFULLY SUPPLIED. EXACT STATEMENT OF OCCUPATION may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78569

CERTIFICATE OF DEATH.

1923 D78569

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Franklin Square Hospital 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Latrice Coad

(a) RESIDENCE No. 240 N Pappleton st. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	21			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Laundry
(c) Name of employer Arches Laundry

9 BIRTHPLACE (city or town) Balt City
(State or country) Md

PARENTS

10 NAME OF FATHER M H Cook

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Julia Russell

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Mr M H Cook
(Address) 240 N Pappleton

15 Filed AUG 3 1923 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-23- 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(inquest, autopsy or inquiry.)~~ find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Severe Burns Nearly body

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Explosion of Boiler

(duration) ..... yrs. ..... mos. 3 ds.

(Signed) H K Somerville, M. D.
(Coroner.)

8-25-1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 8-26 1923

20 UNDERTAKER Denil Easton

ADDRESS 916 Gay

BEFORE FILLING IN CERTIFICATE, REFER TO INSTRUCTIONS ON BACK OF CERTIFICATE.
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78570 — CERTIFICATE OF DEATH. — 100-00D78570

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 W Preston ST.: 17 WARD)

2-FULL NAME Margarette Pauline

(a) RESIDENCE. No. 512 W Preston ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 18 mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col'd	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None.

6 DATE OF BIRTH (month, day, and yenr) Feb 14-1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) Balto City Md.
(State or country)

10 NAME OF FATHER Maynard Pauline

11 BIRTHPLACE OF FATHER (city or town) W. Va.
(State or country)

12 MAIDEN NAME OF MOTHER Edwarda Pauline

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Edwarda Pauline
(Address) 512 W. Preston St

15 Filed ..... 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and yenr) Aug 23- 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 20 1923, to Aug 23 1923

that I last saw her alive on Aug 23 1923

and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Diarrhoea

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopical Examination

(Signed) Samuel A Bunn M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	8-26 1923
20 UNDERTAKER	ADDRESS
Daniel Easter	916 Gay

mation should be carefully supplied. Age should be given in years, months and days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

1658885 D78571

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

32 REGISTERED No. .....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 4 WARD)

2-FULL NAME Ruth Dungee

(a) RESIDENCE No. 231 Myrtle Ave City ST.; ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 5 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of): dau. of Ollie Mother.

6 DATE OF BIRTH (month, day, and year): Aug. 1 1921

7 AGE: Years 2 Months 2 Days 2 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child.
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Ollie

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER Ollie Jessi

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Records.

15 Filed AUG 25 1923 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1923, to Aug 23, 1923, that I last saw her alive on Aug 23, 1923, and that death occurred, on the date stated above, at 1140 A. m.

The CAUSE OF DEATH* was as follows:

Generalized miliary tuberculosis

(duration) ..... yrs. 3 weeks + mos. ..... ds.

CONTRIBUTORY (Secondary) Tuberculous meningitis

(duration) ..... yrs. ..... mos. 7 ds.+

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture

(Signed) A. A. Werch, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL 8-25 1923

20 UNDERTAKER: Denis Eaton — ADDRESS 716 Cath

N. B.—WHITE PRINTED, should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS mation should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

TYPE S.A.F.E.

Spec.-1-10-21 M&T 1500 Blks.

D78572

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78572

CERTIFICATE OF DEATH.

MH-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Marlborough Apts. ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza C. Davidson

(a) RESIDENCE NO. The Marlborough Apts. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 ~~Single, Married, Widowed,~~ or Divorced, (~~write the word~~) Divorced

5a If married, ~~widowed~~ or divorced ~~HUSBAND of~~ (or) WIFE of Robert C. Davidson

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 71 Months 7 Days [redacted] If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lady

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) ~~Name of employer~~

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Samuel Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Trenton N. J.

12 MAIDEN NAME OF MOTHER Eliza Fields

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant E A Jackson

(Address) Reisterstown Md

15 Filed AUG 25 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 4, 1923, to Aug. 24, 1923, that I last saw h[illegible] alive on Aug. 23, 1923, and that death occurred, on the date stated above, at 6.20 A m.

The CAUSE OF DEATH* was as follows:

Hemiplegia Left side

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James C. Clarke, M. D.

Aug 24 1923 (Address) Latrobe Apts, Charles and 25

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Aug 27, 23

20 UNDERTAKER Henry W Jenkins Sons Co

ADDRESS 2216 Mc Culloh Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D A K O

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient—e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic
Stroke

Spec.—1-10-21—M&T—1500 Blks.

D78573

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135 D78573

REGISTERED NO.

1-PLACE OF DEATH
CITY OF BALTIMORE. (No. St. Agnes Hospital ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Conrad Kaufmann

(a) RESIDENCE No. 2110 Ashton st ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 8 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, ~~Married~~, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced. HUSBAND of (or) ~~WIFE of~~ Kate Theresa Kaufmann

6 DATE OF BIRTH (month, day, and year) Dec 12/54

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
68	—	8	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Butcher
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Conrad Kaufmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Stratner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry Rockenstein
(Address) 2110 Ashton st

15 Filed: AUG 25 1923 GS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug-23-1923

17
I HEREBY CERTIFY, That I attended deceased from Aug. 5- 1923 to Aug-23 1923.
that I last saw h- alive on Aug 23- 1923
and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

myocarditis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Aug. 22, 1923

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edward A. Kotlowski, M. D.
(Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cem.

DATE OF BURIAL: 8/25 1923

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans

N. B.—WHITE PAPER, BLACK INK should be used. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of_____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Prostatectomy

Spec.—1-10-21—M&T—1500 Blks.

D78574

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78574

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2222 Christian ST. 20 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie ~~Dr~~ Zehifeld ~~Deems~~

(a) RESIDENCE No. 2222 Christian St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 18, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	6	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. Md (State or country)

PARENTS

10 NAME OF FATHER William J Zehifeld

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country)

12 MAIDEN NAME OF MOTHER Katherine Dolan

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country)

14 Informant William J Deems

(Address) 2222 Christian St

15 Filed AUG 25 1923 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1923, to Aug 23, 1923, that I last saw her alive on Aug 23, 1923, and that death occurred, on the date stated above, at 1:55 a m.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(duration) ..... yrs. ..... mos 1 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? suspected

(Signed) Jas. E. Wells, M. D.

, 19 (Address) 1521 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug 25th 1923
20 UNDERTAKER	ADDRESS
J. A. Worlin	3000 E Balto St

N. B.—WRITE PLAINLY, with ink. All information should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. PHYSICIANS should be stated EXACTLY. PHYSICIANS

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78575

CERTIFICATE OF DEATH.

90 D78575

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2127 Gilmor Ave ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline V. Garrett

(a) RESIDENCE. NO. 2127 Gilmor Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 ~~Single, Married,~~ ~~or Divorced~~ (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Frank D. Garrett

6 DATE OF BIRTH (month, day, and year) July 5, 1849

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
74	1	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Co Md

PARENTS

10 NAME OF FATHER: Richard Rummell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Co Md

12 MAIDEN NAME OF MOTHER: Catherine Reese

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md

14 Informant: Mrs. Mayle Garrett
(Address): 2127 Gilmor

15 Filed AUG 25 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1923, to Aug 24, 1923, that I last saw her alive on Aug 24, 1923 and that death occurred, on the date stated above, at 9-30 P m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

About 2 yrs
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W A Faer M. D

8/25 1923 (Address) 12 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

DATE OF BURIAL: Aug 27 1923

20 UNDERTAKER: J Putnam Hoff

ADDRESS: 1733 Eutaw Pl

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

D78576

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D78576

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 903 N. Broadway (St.) 7 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella E. Nash

(a) RESIDENCE. No. 903 N. Broadway WARD.

(Usual place of abode)

(If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 11 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: deceased Nicholas M. Nash

6 DATE OF BIRTH (month, day, and year): September 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	11	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: James Sesford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Mary E. Mace

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Mrs Stella Sesford 903 N. Broadway

15 Filed AUG 25 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8. 22. 1923.

17 I HEREBY CERTIFY, That I attended deceased from April 1 1923 to August 22 1923.

that I last saw h Er alive on August 22nd 1923.

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hallie H. A. Mey M. D.

23, 1923 (Address) 1021 N. Caroline st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount | DATE OF BURIAL: Aug 25 1923

20 UNDERTAKER: L. Fuselbaugh | ADDRESS: 2620 St Paul

A. B. Names should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be sure that information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be sure that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

78577
D78577

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 44 D78577

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Maryland General Hospital ST., WARD)

2-FULL NAME Mrs. Bates Stephens

(a) RESIDENCE NO. 16 W 24th ST., WARD Dutton Md
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Keller R Stephens

6 DATE OF BIRTH (month, day, and year) Oct 4-1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	10	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER W R Stephens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sallie Tootes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Keller R Stephens
(Address) 16-W-24th St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1923.

17 I HEREBY CERTIFY, That I attended deceased from July 2 1923 to August 24 1923.
that I last saw h[illegible] alive on August 24 1923
and that death occurred, on the date stated above, at 10 a m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home
Did an operation precede death? No Date of 7-24-23.
Was there an autopsy? Yes
What test confirmed diagnosis? General
(Signed) James Hubert Wilkerson, M. D.
19 (Address) Maryland General Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dutton Md	Aug 27 19
20 UNDERTAKER	ADDRESS
H Thurnert Son	Dutton

N. B.—WRITE LEGIBLY. PHYSICIAN'S following information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UG261923 Blair P. Harrison,
Burial Permit Clerk.

Spec.—1-10-21—MAT—1500 [illegible] 78478

Reg. 578 165910

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 84 D78578

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Edwin Snider

(a) RESIDENCE NO. Salem, W. Va R.F.D. 1 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or)~~ WIFE of Lloyd R. (Father),

6 DATE OF BIRTH (month, day, and year) ? ? 1908

7 AGE: Years 15 Months ? Days ? If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) W. Va

(State or country)

PARENTS

10 NAME OF FATHER Lloyd R. Snider

11 BIRTHPLACE OF FATHER (city or town) Va.

(State or country)

12 MAIDEN NAME OF MOTHER Rebeca. Flint

13 BIRTHPLACE OF MOTHER (city or town) W. Va

(State or country)

14 Informant Records. JOHNS HOPKINS HOSPITAL.

(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24 1923.

17 I HEREBY CERTIFY, That I attended deceased from August 22, 1923, to August 24, 1923, that I last saw h in alive on August 24, 1923, and that death occurred, on the date stated above, at 9:38 P m.

The CAUSE OF DEATH* was as follows:

Brain tumor

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? W. Va

Did an operation precede death? Yes Date of 8-24-23

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Warfield M Theobald, M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salem W. Va. DATE OF BURIAL Aug 26 1923

UNDERTAKER H. Harr. Schaffer ADDRESS 1816 Monument

N. B.—WRITE PLAINLY. PHYSICIANS' [illegible] should be stated EXACTLY. AGE should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important. See instructions on back of certificates.

AUG 28 1923

Spec.—1-10-21—M&T—1500 Blks. 78579

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78579 D78579

CERTIFICATE OF DEATH.

X 117

1-PLACE OF DEATH (If not at usual place of residence, give usual place of residence of deceased.) Donato Damiani

CITY OF BALTIMORE: (No. St. Josephs Hospital ST., 9 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniell Dominic

(a) RESIDENCE NO. Piedmont W. Va ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. 14 ds. How long in U. S., If of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 22 1896

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
27	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boiler Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 013

(c) Name of employer: B & O. R. R. Co

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Carmono Domiani

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Filomena Ragni

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Lewis Damiani
(Address) Piedmont W. Va

15 Filed AUG 26 1923, 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 23, 1923, to Aug. 25, 1923, that I last saw him alive on Aug 25, 1923, and that death occurred, on the date stated above, at 6 05 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Pneumonia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) acute appendicitis

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8-24-23

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) J. Norwood Wilson M.D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Piedmont W. Va — DATE OF BURIAL: Aug 26 1923

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 153 W Lombard St

N. B.—WHITE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78580

CERTIFICATE OF DEATH.

90 D78580

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1755 N. Gay ST. 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Rothhauft

(a) RESIDENCE NO. 1755 N. Gay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad F. Rothhauft

6 DATE OF BIRTH (month, day, and year) Nov. 26 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co. (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. J. Hartman

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Laura Harker

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant (Address) Mr. Conrad F. Rothhauft 1755 N. Gay St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25 1923

17 I HEREBY CERTIFY, that I attended deceased from June 1, 1923, to Aug. 25, 1923, that I last saw her alive on Aug 25, 1923, and that death occurred, on the date stated above, at 8.20 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Valvular Regurgitation

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. E. Dunback, M. D.

(Address) 1531 E. Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Aug 27 1923
20 UNDERTAKER	ADDRESS
Henry Hock & Son	1301 E Eager St

Burial Permit Clerk

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78581

CERTIFICATE OF DEATH.

51 D78581

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1923 Brunt ST., 14 WARD)

2-FULL NAME Helen Lucas

(a) RESIDENCE NO. 1923 Brunt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 3, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Austin Lucas

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Fannie Lumpkin

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Fannie Lucas
(Address) 1923 Brunt St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1923

17 I HEREBY CERTIFY, That I attended deceased from July 22, 1923, to Aug 24, 1923, that I last saw her alive on Aug 24, 1923, and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Articular Rheumatism

(duration) yrs. 1 mos 10 ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease

(duration) yrs. 1 mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. William Frey, M. D.

8/25, 1923 (Address) 1928 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

16 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Clythurn Cem — DATE OF BURIAL: Aug 26 1923

20 UNDERTAKER: Wm O'Handley — ADDRESS: Pa Ave

N. B.—NAME, PARENTAGE, AGE, BIRTHPLACE and RESIDENCE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78582 ✓ 124 D78582

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 Division ST. 14 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John E. Jesler

(a) RESIDENCE NO. 1827 Division ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
~~(or) WIFE of~~ HUSBAND of Annie J. Jesler

6 DATE OF BIRTH (month, day, and year) Aug 12, 1863

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
60	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hailer

(b) General nature of industry, business, or establishment in which employed (or employer) Printer

(c) Name of employer

9 BIRTHPLACE (city or town) Stockton
(State or country) Md

PARENTS

10 NAME OF FATHER John E. Jesler

11 BIRTHPLACE OF FATHER (city or town) Stockton
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Pocomoke
(State or country) Md

14 Informant Joseph Coleman
(Address) 1827 Division St

15 Filed ..., 19 ... Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23, 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 13th, 1923, to Aug 22nd, 1923, that I last saw him alive on Aug. 22nd, 1923, and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

CONTRIBUTORY (Secondary) Epithelioma Tongue (duration) 1 yrs. mos ds.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

8/24, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL Aug 26 1923

20 UNDERTAKER David J. Hemsley

ADDRESS W. Balto

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78583

CERTIFICATE OF DEATH.

113 D78583

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 S. Bond ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Proxida Mach

(a) RESIDENCE No. 717 S. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 6 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George . Mach

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimpre Md.

12 MAIDEN NAME OF MOTHER Anna .Golembiewski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mr. George Mach
(Address) 717 S. Bond Street

15 Filed Aug [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 22 1923 to Aug 25 1923, that I last saw h[illegible] alive on Aug 25 1923, and that death occurred, on the date stated above, at 7 p m.

The CAUSE OF DEATH was as follows:*

Uremic Colitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? pending

Signed Fred Reynolds, M. D.

(Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Aug 27 19 23

20 UNDERTAKER John H Weber ADDRESS 1803 Bank St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78584

CERTIFICATE OF DEATH.

32 D78584

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 S ann ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gustawa Kalinowski

(a) RESIDENCE No. 529 S ann ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
		6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Stanislaus Kalinoski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Adelia Lyntowski

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

14 Informant Stanislaus Kalinoski (Address) 529 S ann

15 Filed ....., 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 26 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to Aug 25 1923.

that I last saw h alive on Aug 25 1923

and that death occurred, on the date stated above, at 430 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

(duration) yrs. 1 mos 25 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Kraus M.D.

Aug 26, 19 (Address) 801 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additinnal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	aug 27 1923

20 UNDERTAKER	ADDRESS
John McAleer	1803 Bank

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78585

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78585

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 N. Carlton St. WARD 18)

2-FULL NAME Philip Airey

(a) RESIDENCE NO. 424 N. Carlton Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 10 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Airey

6 DATE OF BIRTH (month, day, and year) Oct 21 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md

PARENTS

10 NAME OF FATHER William Airey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore md

12 MAIDEN NAME OF MOTHER Eliza Youngman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore md

14 Informant Sophia Airey (Address) 424 N. Carlton Ave

15 Filed , 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1923

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1923, to Aug 24, 1923, that I last saw him alive on Aug 24, 1923, and that death occurred, on the date stated above, at 4 20 P. M.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous nephritis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocard. degen.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? urinalysis

(Signed) H. R. Richie M. D.

19 (Address) 619 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Aug 27 1923
20 UNDERTAKER	ADDRESS
Jos Soerdens Son	2173 Pa Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78586

CERTIFICATE OF DEATH.

14-00 D78586

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 W Lee St. ST. 22 WARD)

REGISTERED NO. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles E. Krickhan

(Residence in Baltimore: No. 611 W Lee St St.; 66 yrs., ... mos. ... ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6-DATE OF BIRTH, June (Month) 18 (Day), 1857 (Year)

7-AGE, 66 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Cigar
(b) General nature of industry, business, or establishment in which employed (or employer): Smaker

9-BIRTHPLACE, (State or Country), Balto. Md.

PARENTS.

10-NAME OF FATHER, Charles Krickhan

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M Hook

(Address) 611 Lee St

15-

Filed ..., 19.. ... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 25 (Day), 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1. 1923. to Aug. 25 1923. that I saw h[illegible] alive on Aug. 25 - 1923. and that death occurred, on the date stated above, at 1 - P.M.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Old age

(Duration) ... yrs. ... mos. ... ds.

(Signed) M.D. [illegible] Md. D.

8 25 23, 191.. (Address) 69 W Washington St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Western Cemetery

DATE OF BURIAL, 8-27, 192.3

20-UNDERTAKER Geo Lumbard & Son

ADDRESS 647 W. Pratt St

Burial Permit Clerk.

Spec.—1-10-21—M&T—1500 Bks.

15842 Red 178587

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 078587

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE, (No.) Lilliage

2-FULL NAME ~~Infant Lida~~ Sprouse

(a) RESIDENCE NO. 27 Eutaw Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 14 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	7	"	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER ~~Eagle~~ Sprouse

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Va.

12 MAIDEN NAME OF MOTHER Mary Broyal

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL.
(Address)

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1923, to Aug 25, 1923, that I last saw her alive on Aug 25, 1923, and that death occurred, on the date stated above, at 1-55 P. m.

The CAUSE OF DEATH* was as follows:

Vomiting and diarrhoea (not dysentery)

(duration) ... yrs. ... mos 10 ds.

CONTRIBUTORY (Secondary) X

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Mt. Wilson Sanitarium

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical course

(Signed) H. H. Mitch, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green spring Va.

DATE OF BURIAL Aug 26 1923

20 UNDERTAKER Robt J Turner Inc

ADDRESS 1442 N Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78588

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78588

58-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Greenway apts ST. 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Hill Brittain

(a) RESIDENCE No. Charles + 34th ST. S WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. — How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm M. Brittain

6 DATE OF BIRTH (month, day, and year) March 10-1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER John Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Signed Milne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Wm M. Brittain

(Address) Charles + 34th Sts

15 Filed . 19 Registrar

AUG 28 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25 1923

17 I HEREBY CERTIFY, That I attended deceased from July 7 . 1923 , to Aug. 25 . 1923 , that I last saw her alive on Aug. 24 . 1923 , and that death occurred, on the date stated above, at 4:00 A m.

The CAUSE OF DEATH* was as follows:

PERNICIOUS ANEMIA

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Exam. etc.

(Signed) John L. Dorsey M. D.

. 19 (Address) 1008 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	8/27 1923
UNDERTAKER	ADDRESS
Chas. F. Evans & Son	118 W. Mt. Royal ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(Dr Hoyt 26 - E. Preston)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78589

CERTIFICATE OF DEATH.

74-001 D78589

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1934 (Street) Linden Ave (Ward)

2-FULL NAME Julia H. White

(a) RESIDENCE NO. 1934 (Street) Linden Ave (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David H. White

6 DATE OF BIRTH (month, day, and year): Aug 30 - 1852

7 AGE: Years 71 | Months | Days 25 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Richard Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Julia Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Esther E. White

(Address) 1934 Linden Ave

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 25 1923

17 I HEREBY CERTIFY, That I attended deceased from ..., 1920, to Aug 25, 1923, that I last saw him alive on Aug 25, 1923, and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) (duration) 3 yrs. mos. ds. Respiratory Failure (duration) yrs. 6 mos hrs

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Ralph Leigh M. D.

, 19 (Address) 26 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dealls Island, Md. DATE OF BURIAL: Aug 28 1923

20 UNDERTAKER: Herman Cook ADDRESS: 502 E Nor

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S STATE
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC
TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78590

CERTIFICATE OF DEATH.

49 D78590

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1408 Marshall (St.) 23 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eli Bangs

(a) RESIDENCE. No. 1408 Marshall St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, ~~Widowed~~, or ~~Divorced~~ (write the word)

(a) If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Sarah Bangs

6 DATE OF BIRTH (month, day, and year) 1-2-1836

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Cooper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Eli Bangs

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Schmuck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant E. L. Bangs
(Address) 16 Ruckert Rd Hamilton

15 Filed . 19 Registrar

AUG 26 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1923

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1923, to Aug 24, 1923, that I last saw him alive on Aug 23, 1923, and that death occurred, on the date stated above, at 5.20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate gland

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phy

(Signed) Wm Lebkicher, M. D.

8/25, 1923 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Aug 27 1923

20 UNDERTAKER Wm Cook

ADDRESS 502 E Monument St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78591 D78591

CERTIFICATE OF DEATH.

REGISTERED NO. 47

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2822 St. Paul ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles M. Faulkner

(a) RESIDENCE. No. 2822 St. Paul ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elsie L. Faulkner

6 DATE OF BIRTH (month, day, and year) July 29 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dept Store

(b) General nature of industry, business, or establishment in which employed (or employer) Bernheimer Bros

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Faulkner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Emily Faulkner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Elsie L. Faulkner
(Address) 2822 St Paul St.

15 Filed AUG 26 1923 Robert P. Harrison Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25th 1923

17 I HEREBY CERTIFY, That I attended deceased from July, 1923, to Aug 25th, 1923, that I last saw him alive on Aug 24th, 1923, and that death occurred, on the date stated above, at 12.10 P. m.

The CAUSE OF DEATH* was as follows:

Scirrhous Carcinoma (Left Breast)
Carcinomatosis (Lungs & General)

(duration) yrs. 5+ mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus (duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 1923

Was there an autopsy? No

What test confirmed diagnosis? Tissue exam. X-ray etc

(Signed) Walter E. Gumpler, M. D.

. 19 (Address) 1013 Poplar Grove St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Aug 28 1923
20 UNDERTAKER	ADDRESS
Wm. Cook	501 E Northern

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 B4a.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78592

CERTIFICATE OF DEATH.

100-00 D78592

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 21 WARD)

2-FULL NAME Mrs. Celeste Hoffmann

(a) RESIDENCE NO. 1159 Washington Boulevard WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White.	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Hoffman.

6 DATE OF BIRTH (month, day, and year) Feb. 28, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	19	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland Balto

PARENTS

10 NAME OF FATHER Jesse Albright

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Annie Orndorff.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Hosp. records.

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 25, 1923.

17

I HEREBY CERTIFY, That I attended deceased from Aug. 22, 1923, to Aug. 25, 1923, that I last saw h[illegible] alive on Aug. 25, 1923; and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Pregnancy complicated by Chorea, insania.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) B. M. Rhodes, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet

DATE OF BURIAL aug 27, 1923

20 UNDERTAKER Mc Mrs. J. W. Teufel & Son

ADDRESS 801 N. Fayette

Robert P. Morrison,
Chief Permit Clerk.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupa... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78593 48 D78593

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH
CITY OF BALTIMORE, (No.) 3527 Falls Road ST. 13 WARD)

2-FULL NAME Alice M. Murphy

(a) RESIDENCE NO. 3527 Falls Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~

6 DATE OF BIRTH (month, day, and year) July 6-1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21	1	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of Industry, business, or establishment in which employed (or employer) 109
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS
10 NAME OF FATHER Roger E. Murphy
11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co Md
12 MAIDEN NAME OF MOTHER Alice M Murphy
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co.

14 Informant Roger E Murphy
(Address) 3527 Falls Road

15 Filed ..... 19 ..... Registrar
AUG 28 1923 Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1923, to Aug. 25, 1923, that I last saw h.r alive on Aug. 25 1923, and that death occurred, on the date stated above, at 6 00 A. m.

The CAUSE OF DEATH* was as follows:
Carcinoma of naso-pharynx

(duration) — yrs. 7 mos — ds.

CONTRIBUTORY (Secondary) Myocardial insuff.
(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb. 10/23.

Was there an autopsy? No

What test confirmed diagnosis? Microscopic-glands.

(Signed) Dudley P. Bowd, M. D.

. 19 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: Aug 27 23

20 UNDERTAKER: A S Marshall — ADDRESS: 3538 Federal

N. B.—WRITE PLAINLY, with ink. All items must be supplied. AGE should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78594

CERTIFICATE OF DEATH.

'90 D78594

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1844 Wilkins Ave ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wallace Mabbett.

(a) RESIDENCE No. 1844 Wilkins Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marguetha Mabbett.

6 DATE OF BIRTH (month, day, and year): Oct. 30 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	10	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman. 062

(b) General nature of industry, business, or establishment in which employed (or employer): Shirt Factory

(c) Name of employer: Sonneborn Clothing Co.

9 BIRTHPLACE (city or town) (State or country): Brooklyn, N.Y.

PARENTS

10 NAME OF FATHER: William Mabbett

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.Y.

12 MAIDEN NAME OF MOTHER: Margaret McCollum 8-24 1923

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.Y.

14 Informant: Mrs. Katie Segal (Daughter)

(Address): 1844 Wilkins Ave

15 Filed AUG 26 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 23rd 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 2nd, 1923, to Aug 23rd, 1923, that I last saw him alive on Aug 22nd, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 2 8 ds.

CONTRIBUTORY (Secondary): Chronic Valvular Endocarditis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Examination

(Signed) L. L. Gordy M. D.

(Address) 4218 Harford Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Aug 27 1923
20 UNDERTAKER: Joseph B. Cook	ADDRESS: 1003 W. Balto St.

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78595

CERTIFICATE OF DEATH.

129 D78595

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 124 West Belvedere Ave. ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert E. Hammond

(a) RESIDENCE NO. 124 West Belvedere Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of May Griffith Hammond

6 DATE OF BIRTH (month, day, and year) Dec. 28"1867

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or min.
55	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired (Motorman)

(b) General nature of industry, business, or establishment in which employed (or employer) Street Railway

(c) Name of employer United Railway

9 BIRTHPLACE (city or town) Balto. Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER John D. Hammond

11 BIRTHPLACE OF FATHER (city or town) Frederick Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary A. Kemp

13 BIRTHPLACE OF MOTHER (city or town) Howard Co. Md.
(State or country) Maryland

14
Informant Mrs. May Hammond
(Address) 124 West Belvedere Ave.

15
Filed ..., 19.. Robert P. Garrison.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August, 24th. 19 23

17

I HEREBY CERTIFY, That I attended deceased from Apr 10, 1923, to Aug 24, 1923,
that I last saw him alive on Aug 24, 1923,
and that death occurred, on the date stated above, at 1 P. m.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

Oedema of Lungs (duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? Place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam & Examination

(Signed) John D. Raymond M. D.

8/25, 1923 (Address) 1219 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Aug 27 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 W. Balto St.

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. Information as to CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Tabs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78596

CERTIFICATE OF DEATH.

129 D78596

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 945 Sterling ST.; 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Cornish

(Residence in Baltimore: No. 945 Sterling St.; 40 yrs., — mos. — ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, B

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH, Sept 6, 1852 (Month) (Day) (Year)

7-AGE, 61 yrs. ..... mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Service (H)

9-BIRTHPLACE, (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown.

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. R.C. Elliott

(Address) 1725 Ashland ave.

15-

AUG 26 1923

Filed....., 191.....

Robert P. Harrison, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 23, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 16 1923, to Aug 23 1923, that I saw h[er] alive on Aug 23 1923, and that death occurred, on the date stated above, at 9.38 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nefritis

..... (Duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

..... (Duration) ..... yrs. 1 mos. ..... ds.

(Signed) A.F. Hurwitz M. D.

8/25, 1923 (Address) 733 Ausprich St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, St. Peters Cemetery — DATE OF BURIAL, Aug 27 1923

20-UNDERTAKER Mrs. R.C. Elliott — ADDRESS 1725 Ashland ave.

N. B.—Every item of information should be given so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

165918, D78597

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78597

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 5 40 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 5 WARD)

2-FULL NAME Evelyn Stanley.

(a) RESIDENCE NO. 5204 Central Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (or) WIFE of Ernest Stanley (Husband)

6 DATE OF BIRTH (month, day, and year) Jan 15, 1899.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
24	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER People ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Record (Address) JOHNS HOPKINS HOSPITAL.

15 Filed AUG 26 1923, 19 Robert P. Harrison. Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1923, to Aug 24, 1923, that I last saw her alive on Aug 24, 1923, and that death occurred, on the date stated above, at 7 05 P. m.

The CAUSE OF DEATH* was as follows:

Acute Bacterial Endocarditis

(duration) yrs. mos 24 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas. W. Wainwright, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk Va	Aug 27 1923
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1725 Ashland

A. B. C. mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

16664
16598

HEALTH DEPARTMENT—CITY OF BALTIMORE

36-005
36 D78598

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 11 WARD)

2-FULL NAME Harry Smith

(a) RESIDENCE NO. 1202 Guilford Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Georgia

6 DATE OF BIRTH (month, day, and year): Sept 9-1886

7 AGE: Years 36 | Months 11 | Days 14 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: George

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mabel Stockley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: JOHNS HOPKINS HOSPITAL. (Address)

15 Filed AUG 26 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1923, to Aug 23, 1923.

that I last saw him alive on Aug 23, 1923.

and that death occurred, on the date stated above, at 6 32 P. m.

The CAUSE OF DEATH* was as follows:

Pyonephrosis + nephrolithiasis

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Tuberculosis of seminal + vesicle (duration) 2 yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Feb 14, 1923

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Eugene C. Shaw M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Aug 27, 1923

20 UNDERTAKER: John F Denny — ADDRESS: 715 Light St

IMPORTANT. Information should be carefully supplied. AGE should be stated EXACTLY. Information of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78599

164765

CERTIFICATE OF DEATH.

X 90

D78599

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7 WARD)

2-FULL NAME Charles L. Davis

(a) RESIDENCE NO. Warm Springs Ga ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. 2 about mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) May 11, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel Prop. 086

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Ga

PARENTS

10 NAME OF FATHER John Davis

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Ga

12 MAIDEN NAME OF MOTHER Georgia C. Mustian

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Ga

14 Informant JOHNS HOPKINS HOSPITAL. (Address)

15 Filed ....., 19 ..... Registrar G G.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26th 1923

17 I HEREBY CERTIFY, That I attended deceased from June 29th, 1923, to Aug 26th, 1923, that I last saw him alive on Aug 26th, 1923, and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) ..... yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Georgia

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Treva Owen, M. D.

Aug 26 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Columbus, Ga.	Aug. 27, 1923

20 UNDERTAKER John O. Mitchell ADDRESS 120 W. Fayette St.

N. B.—All information should be carefully supplied. AGE should be stated EXACTLY. Information in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78600 ✓ 155 D78600

CERTIFICATE OF DEATH.

D78600

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Wisneski

(a) Residence No. 2213 E. Pratt St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1919

7-AGE, 4 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9-BIRTHPLACE (city or town) Balto (State or Country),

PARENTS.

10-NAME OF FATHER, Charles Wisneski

11-BIRTHPLACE OF FATHER (city or town) Poland (State or Country),

12-MAIDEN NAME OF MOTHER, Carrie Luerbe

13-BIRTHPLACE OF MOTHER (city or town) Poland (State or Country),

14- (Informant) Hospital Record

(Address)

15-

Filed ..... 192..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 25-23

17- I HEREBY CERTIFY, That I attended deceased from 7/26/23, 19..... to 8/25/23, 19.....

that I last saw h alive on 8/25/23, 19.....

and that death occurred, on the date stated above, at 10.10 a. m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis (Multiple)

(Rt femur, Rt thumb; Left tarsal bones; Rt knee;

(Duration) yrs. mos. 27 ds.

CONTRIBUTORY (Secondary) Septicemia

(Duration) yrs. mos. 12 ds.

18-Where was disease contracted if not at place of death? at 2213 E. Pratt

Did an operation precede death? Yes Date of 7/27/23

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Surgical

(Signed) K. W. Kolb M. D.

, 19 (Address) Mercy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary — DATE OF BURIAL, 8/28/23 19....

20-UNDERTAKER Fred W Ozarowski — ADDRESS 1930 Eastern Ave

should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Not tubercular

Spec.—6-9-19—H. P. Co.—1000 Bks. 78499

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

160 ✓

D78601

D78601

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2424 Maryland ave. (St.) 12 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edw William Eckmeyer.

(a) RESIDENCE. No. 2424 Maryland ave. St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 29 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4		

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Herman Eckmeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Margt Bruyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant Margt Eckmeyer
Address 2424 Maryland ave.

15 Filed AUG 27 1923 . 19 . Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 25 1923

17

I HEREBY CERTIFY, That I attended deceased from April 29. 1923. to August 25. 1923.
that I last saw h alive on August 25. 1923
and that death occurred, on the date stated above, at 1130 m.
The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) Since birth yrs. mos. ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo M Settle, M. D.

Aug 25 1923 (Address) 2435 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	Aug 27 1923
20 UNDERTAKER E. A. Woodfield Jr	ADDRESS 516 22d.

N. B.—WHITE PLAINLY. MAIDEN NAME OF MOTHER should be stated EXACTLY. PHYSICIANS should state AGE should be carefully supplied. AGE should be carefully supplied. PHYSICIANS should state mation should be carefully supplied. AGE should be carefully supplied. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

D78602

Form (No. 1) B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78602

CERTIFICATE OF DEATH.

Registered No. 6182

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tubercular Hospital St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick A. Johnson.

(a) Residence No. 821 Pearce St. Balto. Md. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mrs. F.A.Johnson

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE.	If LESS than 1 day.
55 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Barber 004

(b) General nature of industry, business, or establishment in which employed (or employer) Barber

(c) Name of employer Unknown

9-BIRTHPLACE (city or town) South Carolina (State or Country)

PARENTS.

10-NAME OF FATHER, Fred Johnson

11-BIRTHPLACE OF FATHER (city or town) (State or Country), South Carolina

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), South Carolina

14- (Informant) F.A.Johnson
(Address) 821 Pearce St.

15- Filed AUG 27 1923 G.G. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-23-23

17- I HEREBY CERTIFY, That I attended deceased from June 7 1923 to Aug 23 1923

that I last saw h. im alive on August 23 1923

and that death occurred, on the date stated above, at 5.30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Secondary Broncho Pneumonia

(Duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum & X-ray

(Signed) L. A. Lally M. D

, 19 (Address) Bay View H.B. Balto.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Druid Hill Cemetery	Aug 27 1923
20-UNDERTAKER, Edward Bryan	ADDRESS 1631 Orleans St.

should be carefully supplied. Also answer all questions in plain terms, so that it may be properly classified. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Blks.

D78603

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-001 ✓ 24 D78603

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

CITY OF BALTIMORE: (No. 1803 N. Caroline ST. WARD)

2-FULL NAME Mary C. Kinghton (Knighton)

(a) RESIDENCE NO. 1803 N Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

6a If married, widowed or divorced HUSBAND of (or) WIFE of James F Knighton

6 DATE OF BIRTH (month, day, and year) 12-12-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City (State or country)

PARENTS

10 NAME OF FATHER John House

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Sarah Bulby

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Mrs. F. Knighton (Address) 1803 N. Caroline

15 Filed AUG 27 1923 192 G. H. Grese Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. a few mos. hrs.

CONTRIBUTORY (Secondary) Don't Know

(duration) yrs. mos. ds.

(Signed) H. B. Jones, M. D. (Coroner)

Aug 27, 1923 (Address) 1111 Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk Cemetery — DATE OF BURIAL 8/28 1923

20 UNDERTAKER George J Ruth — ADDRESS 1935 Hanford Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause TION is very important. See instructions on back of certificate.

K.S.A.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

078604

CERTIFICATE OF DEATH.

101-001

078604

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No Maryland Penitentiary ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo Clark.

(a) RESIDENCE. No. Unknown ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General Odd

(b) General nature of industry, business, or establishment in which employed (or employer): Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant H. L. Farring
(Address) Aberdeen Md

15 Filed ..... 19 AUG 27 1923 G. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 25 1923

17

I HEREBY CERTIFY, That I attended deceased from August 14 1923, to August 25 1923, that I last saw h im alive on August 25 1923, and that death occurred, on the date stated above, at 1.15 p. m.

The CAUSE OF DEATH* was as follows:

Toxemia and Cardiac Failure

(duration) yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) William H. Schwarz, M. D.

8/25, 1923 (Address) Maryland Penitentiary,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Aberdeen Md	Aug 27 1923

20 UNDERTAKER H. F. Tuckwell & Son ADDRESS Bel Air

mation should be carefully supplied. Age should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78605 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-00 D78605

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 306 E Lanvale St. 17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Rubl

(a) RESIDENCE No. 306 E Lanvale St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret Rubl

6 DATE OF BIRTH (month, day, and year) April 11 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	75	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) U.S. Navy

(c) Name of employer Department

9 BIRTHPLACE (city or town) Baltimore Co
(State or country) Md

PARENTS

10 NAME OF FATHER Peter Rubl

11 BIRTHPLACE OF FATHER (city or town) Balto Co
(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Matthews

13 BIRTHPLACE OF MOTHER (city or town) Balto Co
(State or country) Md

14 Informant Howard F. Rubl
(Address) 306 E Lanvale St

15 Filed AUG 27 1923 G. H. Crest Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 18 1923 to Aug 25 1923 that I last saw him alive on Aug 25 1923 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 7 da.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Dr. H. P. Beard M. D.

, 19 (Address) 2105 N Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem — DATE OF BURIAL Aug 28 1923

20 UNDERTAKER H. J. Lukens & Sons — ADDRESS Hollins

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. Numerals should be used. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78606

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

119 D78606

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Gen Hospt ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Gordon (Charles Elsworth Gordon)

(a) RESIDENCE NO. 242 Lombard St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Fannie E Gordon

6 DATE OF BIRTH (month, day, and year) July 8 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	76	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Jno. E. Gordon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Katherine Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Fannie Gordon (Address) 242 Lombard Street

15 Filed , 19 G. H. Crese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-26-1923

17

I HEREBY CERTIFY, That I attended deceased from 5-5-23, to 8-26-23, 19 ,

that I last saw h alive on 8-26-23, 19 ,

and that death occurred, on the date stated above, at 7 45 a m.

The CAUSE OF DEATH* was as follows:

Influenza pneumonia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) yrs. mos. 28 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clynical Symptoms

(Signed) Jno A Compton, M. D.

, 19 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem DATE OF BURIAL Aug 28 1923

20 UNDERTAKER P. J. Tucker & Son ADDRESS Northern

N. B. All information should be carefully supplied. AGE should be stated EXACTLY. Information on CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not Known

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

45 D78607

D78607

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2027 Cecil Ave ST., 9 WARD)

2-FULL NAME William C Baxter Sr.

(a) RESIDENCE NO. 2027 Cecil Ave ST., 9th WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marjory McLean Baxter

6 DATE OF BIRTH (month, day, and year) Aug 8th 1862 ✓

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
61	0	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman Stone Cutter ✓

(b) General nature of Industry, business, or establishment in which employed (or employer) Stone Contractors

(c) Name of employer Clough & Medley ✓

9 BIRTHPLACE (city or town) (State or country) Glasgow Scotland

PARENTS

10 NAME OF FATHER Thomas Baxter

11 BIRTHPLACE OF FATHER (city or town) Glasgow (State or country) Scotland

12 MAIDEN NAME OF MOTHER Jessie Brown

13 BIRTHPLACE OF MOTHER (city or town) Glasgow (State or country) Scotland

14 Informant Mrs. Wm C Baxter (Address) 2027 Cecil Ave

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1923

17 I HEREBY CERTIFY, That I attended deceased from June 4th, 1923, to Aug 25, 1923, that I last saw him alive on Aug 25, 1923, and that death occurred, on the date stated above, at 11.40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Colon

(duration) 1 yrs mos ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. 2 mos. 21 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Yes Date of June 11th 1923

Was there an autopsy? No

What test confirmed diagnosis? operation - Autopsy Carcinoma

(Signed) Geo McLean, M. D.

8/25, 1923 (Address) 20 E Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Aug 28 '23
20 UNDERTAKER	ADDRESS
H. Friedwald's	Monument

mation should be carefully supplied. AGE should be stated EXACTLY. Abbreviations CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78608

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 10 - Carroll ST., [illegible] WARD

REGISTERED NO. 161-001 D78608

(If death occurred in a hospital or institution, give NAME instead of street and number.)

2-FULL NAME Helena LeTohadia Lee

(a) RESIDENCE NO. 10 - Carroll ST., 25 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

If non-resident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year) Aug 26 1923

7 AGE: Years | Months | Days: 4 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): Infant

(c) Name of employer: Infant

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Boris Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Fanny Kaczutinska

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Frank Kaczutinska

(Address) 10 - Carroll Park City.

15 Filed AUG 27 1923 G. E. Cross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 22, 1923, to Aug 26 1923, that I last saw h[illegible] alive on Aug 22 1923, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Convulsions of Head and Back " recurrent after birth and convulsive attacks

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? N U Date of —

Was there an autopsy? N U

What test confirmed diagnosis? None

(Signed) William A Scott M. D.

(Address) Aug 26 1923 816 Cumberland Row

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross — DATE OF BURIAL: 8/29 1923

UNDERTAKER: William Fallsaw & Co ADDRESS: 168 Eastern Ave

CORONER FOR BALTIMORE CITY EASTERN DISTRICT

Should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78609

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78609

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 7 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Vocden

(a) RESIDENCE NO. 614 N. Spring St. ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver 23

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George Wooden

11 BIRTHPLACE OF FATHER (city or town) (State or country) West River, Md.

12 MAIDEN NAME OF MOTHER Anna Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co., Md.

14 Informant Municipal Hospital Records.
(Address)

Filed AUG 27 1923 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 24, 23

17

I HEREBY CERTIFY, That I attended deceased from July 3, 19 23. to August 24, 19 23.

that I last saw him alive on August 24, 19 23.

and that death occurred, on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Right Hemiplegia (Residual)

(duration) yrs. 2 mos ..... da.

CONTRIBUTORY (Secondary) (Immed.) Broncho-Pneumonia (duration) ..... yrs. ..... mos. 4 da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude B. Hince, M. D.

8-25-23, 19 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel	Aug 28 23

20 UNDERTAKER John W Henderson ADDRESS 1502 E. Monument

N.B. All information should be carefully supplied. AGE should be stated EXACTLY. Particulars of OCCUPATION may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See Instructions on back of certificates. TION is very important.

Spec. 12-23-21—E.B.R.S.—400 Bks.

D78610

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002 D78610

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 430 N. Payson St. St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret M. Holehan

(a) Residence No. 430 N. Payson St. St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. — mos. — ds. How long in U. S., if of foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of John E. Holehan

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE,	If LESS than 1 day,
74 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Ireland.

PARENTS.

10-NAME OF FATHER, Mr. Brebruter

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Irland

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) John E. Holehan

(Address) 430 N. Payson St.

15- Filed..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 26 '23

17- I HEREBY CERTIFY, That I attended deceased from Aug. 22, 1923 to Aug. 26 1923

that I last saw h. alive on " " 1923

and that death occurred, on the date stated above, at 11.50A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis (5yrs)

Acute Intestinal Intoxication

(Duration) yrs. mos. 4 ds

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 2 ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. J. Coolahan M. D.

8/25/23 (Address) 24 N. Fulton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL,
St. Vincents Cemetery	Aug 29 1923
20-UNDERTAKER.	ADDRESS
Henry Hoerr Son	501 Eager St

Should be answered in full. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D78611

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78611

129 Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 860 N Lexington St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Bull

(a) Residence No. 860 N Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Elijah E Bull

6-DATE OF BIRTH (month, day and year) March 3 1837

7-AGE, 86 yrs. 5 mos. 23 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, John Mullis

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Baltimore Md

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Baltimore Md

14- (Informant) Virgie E Marshall

(Address) 860 N Lexington

15- Filed, 1926 C. H. Grese Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 26 23

17- I HEREBY CERTIFY, That I attended deceased from July 18 19 23 to Aug 26 19 23

that I last saw h.. alive on Aug 23 19

and that death occurred, on the date stated above, at 10a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Contributory Influenza

(Duration) unknown yrs. mos. ds.

CONTRIBUTORY Diarrhea

(Secondary)

(Duration) yrs. mos. 7 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Bernard L Berry, M. D.

Aug 26, 1923 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Loudon Park Aug 28 1923

DATE OF BURIAL,

20-UNDERTAKER, Williamson & E Norris

ADDRESS

Should be carefully considered and in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78612

CERTIFICATE OF DEATH.

90 D78612 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 302 W. Mosher ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Harding

(a) RESIDENCE NO. 302 W Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Edward S. Harding

6 DATE OF BIRTH (month, day, and year) 12-8-1843

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. Wolfe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Joseph W. Deberts

(Address) 301 Dolphin

15 Filed ..... 19.. G. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1923

17

I HEREBY CERTIFY, That I attended deceased from May 29, 1923, to Aug 26, 1923, that I last saw h[illegible] alive on Aug 25, 1923, and that death occurred, on the date stated above, at 1 15 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Chas F Heuisler, M. D.

(Address) 1504 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Aug 28 1923
20 UNDERTAKER Wm Cook	ADDRESS 502 E Nath

AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N Clarence 1506 Linecullough

Cor.—1.12.D. M&T—10 6½.

D78613

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78648

CERTIFICATE OF DEATH.

REGISTERED NO.....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. John Hopkins ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2—FULL NAME Helen Mary Lewis

(a) RESIDENCE NO. 710 Aisquith ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 2, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas Lewis Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Anna B. Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Edna Lewis (Address) 710 Aisquith

15 Filed ..... 192 ..... C. H. Cone Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Dysentery

Days (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... (Coroner) ....., M. D.

August 26, 1923 (Address) 1639 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.) In the City ..... yrs., ... mos., ... ds. State ..... yrs., ... mos., ... ds.

At place of death ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence 710 Aisquith St

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fredericksburg Va

DATE OF BURIAL 25 1923

20 UNDERTAKER Wm Cole

ADDRESS 502 E Balto St

mation should be carefully supplied. Exact statements should be properly classified, so that it may be properly coded. Write plainly in ink. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statements should be properly classified. See instructions on back of certificate. TION is very important.

Cor.—1-12-23—M&T—100 Bks.

D78614

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78614

CERTIFICATE OF DEATH.

REGISTERED NO. 89

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 21 N. Wolf ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Aaron Lichtestein

(a) RESIDENCE NO. 21 N. Wolf ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Kate Lichtestein

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	42	4	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Furrier
(b) General nature of industry, business, or establishment in which employed (or employer) Himself
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Lichtestein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rosa

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mollie Feinstein
(Address) 1810 Fairmount Av

15 Filed ..... 192 ..... G. H. Cook Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 25 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Sudden (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) W. H. Ruby M. D.
(Coroner.)
Dec 27 192 3 (Address) 1639 Bway

*Give the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehsen Mt Carmel DATE OF BURIAL 12/28 192 3

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78615

CERTIFICATE OF DEATH.

185 D78615

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2121 Eharl ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elizabeth Romuer

(a) RESIDENCE NO 2121 Eharl ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. — mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	white	Married

5a If married, widowed, ~~or divorced~~ HUSBAND of ~~(or) WIFE of~~ Herman Romuer

6 DATE OF BIRTH (month, day, and year) 1856.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	6	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... H. wife
(b) General nature of industry, business, or establishment in which employed (or employer) 37
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Michael Filbert

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant H. Romuer
(Address) 2121 Eharl

15 Filed AUG 27 1923 S. H. Grese Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract skull - + rt
Down Stairs accidental
Few minutes (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....
(duration) ... yrs. ... mos. ... ds.

(Signed) Jos Kelly M. D.
(Coroner.)
Aug 27 1923 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Aug 27 1923
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans St.

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78616

CERTIFICATE OF DEATH.

129 D78616

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3227 Philadelphia St., Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph B. Storath

(a) RESIDENCE No. 3257 Phila. Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? 53 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late Mary Storath

6 DATE OF BIRTH (month, day, and year): Mar 10 53

7 AGE — Years: 70 — Months: 5 — Days: 16 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer): 003

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Adolph Storath

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Wm Stumpf
(Address) 3227 Phila Ave

15 Filed AUG 27 1923 C. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug. 16, 1923 to Aug 26, 1923 that I last saw h[illegible] alive on Aug 26 1923 and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis and Arterio-Sclerosis

Atrial (duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms and Urine

(Signed) Edw L Mattin M. D.

Aug 27 1923 (Address) 224 E 39

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: 8/27 1923

20 UNDERTAKER: Philip Herwig — ADDRESS 2016 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. Illegible CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78617 — 161 — 001 ✓ — D78617

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2022 Division ST. 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Boyer.

(a) RESIDENCE No. 2022 Division ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30th 23

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sergeant.

(b) General nature of industry, business, or establishment in which employed (or employer) U.S.

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Edw. F. Boyer.

11 BIRTHPLACE OF FATHER (city or town) City
(State or country)

12 MAIDEN NAME OF MOTHER Hilda Fonsha

13 BIRTHPLACE OF MOTHER (city or town) City
(State or country)

14 Informant Mrs. Fonsha
(Address) 2022 Division St.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 30th 23. to Aug 26th 23.
that I last saw h[illegible] alive on Aug 25th 23.
and that death occurred, on the date stated above, at 10. A. m.

The CAUSE OF DEATH* was as follows:

Marasmus + Inanition following Premature Birth 7½ months

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? Physical

(Signed) Harry F. Brown, M. D.

8/27 1923 (Address) 601 Presstman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Aug 27 1923

20 UNDERTAKER	ADDRESS
Clarence E. Wright	1364 W. Lanvale

mation should be carefully supplied. AGE should be stated EXACTLY. Information
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T- 1500 Bks.

D78618

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78618

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Samuels

(a) RESIDENCE NO. 242 Browers Court ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Anna Co., Md.

PARENTS

10 NAME OF FATHER Marshall Samuels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Wolfard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Municipal Hospital Records.

(Address)

AUG 27 1923

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 23 19 23

17

I HEREBY CERTIFY, That I attended deceased from June 8, 19 23, to August 23, 19 23,

that I last saw her alive on August 23, 19 23,

and that death occurred, on the date stated above, at 11:00 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Right tubo ovarian abscess.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 28, 23.

Was there an autopsy? Yes.

What test confirmed diagnosis? Operation + Autopsy

(Signed) Wm. J. Fulton, M. D.

8-25-23, 19 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Old Bethlehem Cem	Aug 27, 19 23

20 UNDERTAKER Brown & Buckland Bethesda

ADDRESS 1402

N. B. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should see that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78619 HEALTH DEPARTMENT—CITY OF BALTIMORE D78619

CERTIFICATE OF DEATH.

31

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1823 W Saratoga ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Brown

(a) RESIDENCE NO. 1823 W. Saratoga St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

N. B.—WARNING—Entries must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar. 15, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
53, 1870		Months	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md. County

PARENTS

10 NAME OF FATHER: David Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Caroline Eades

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Mary Fielson 1823 Saratoga

15 Filed ....., 19.... Registrar

AUG 27 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 24 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 19, 1923, to Aug. 24, 1923, that I last saw h[illegible] alive on Aug. 24, 1923 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Mitral Regurgitation

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James M Hayes, M. D.

Aug 27 1923 (Address) 1913 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Aug 29 1923

20 UNDERTAKER: Brown Fitzpatrick & Leach ADDRESS 114

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Pulmonary Tuberculosis

Spec.—1-10-21—M&T—1500 Blks.

D78620 HEALTH DEPARTMENT—CITY OF BALTIMORE D78620

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 N Schroeder ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Robinson

(a) RESIDENCE NO. 202 N Schroeder ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Blk	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug 18th/23

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
			15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm Robinson

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Fannie Broadus

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Wm Robinson

(Address) 202 Schroeder

15 Filed ..., 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/26 1923

17

I HEREBY CERTIFY, That I attended deceased from aug 11th, 1923 to aug 26, 1923.

that I last saw him alive on aug 25, 1923,

and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustav Goldman M. D.

, 19 (Address) 656 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lebanon	aug 27 1923

20 UNDERTAKER Brown & Freeland ADDRESS 114

mation should be carefully supplied. AGE should be stated EXACTLY. Erasures or alterations CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21–E.B.R.S.–400 Bks.

D78621 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 D78621

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tubercular Hospital St., 36 Ward)

Registered No. 6077

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Rolfes

(a) Residence No. 223 S. Highland Ave. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of August Rolfes

6-DATE OF BIRTH (month, day and year)

7-AGE: 23 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

037

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of Industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer: At Home

9-BIRTHPLACE (city or town) (State or Country): Maryland

PARENTS

10-NAME OF FATHER: Frank Vondracek

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Czech-Slav

12-MAIDEN NAME OF MOTHER: Christine Dvorak

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Czech-Slav

14-

(Informant): August Rolfes

(Address): 223 S. Highland Ave.

15-

Filed ..... 192 .....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 8-24-23

17- I HEREBY CERTIFY, That I attended deceased from Apr. 4 1923 to Aug. 24 1923

that I last saw h... alive on Aug. 24 1923

and that death occurred, on the date stated above, at 5.05 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. 7 mos. ds.

18-Where was disease contracted if not at place of death? Husband Tubercular

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Sputum & X-ray

(Signed) L. A. Lally M. D

, 19 (Address) Municipal T.B. Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Aug. 28, 1923

20-UNDERTAKER: Lilly & Zeiler — ADDRESS: 403 S. Wolfe St.

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-1021—M&T—1500 Bks.

D78622

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78622

CERTIFICATE OF DEATH

5 418-002

1-PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Fawcett & green ST. 5 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Southerne

(a) RESIDENCE NO. 1843 McHenry ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 5 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 25-1918

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 0 0 0

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Benj Southerne

11 BIRTHPLACE OF FATHER (city or town) N.C.
(State or country)

12 MAIDEN NAME OF MOTHER Caroline Wertheimer

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Hosp. Records
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-25- 1923

17

I HEREBY CERTIFY, That I attended deceased from 8-24 , 1923 , to 8-25- , 1923

that I last saw him alive on 8-25- , 1923

and that death occurred, on the date stated above, at 6.08 A m.

The CAUSE OF DEATH* was as follows:

myocardial insufficiency

post operative adhesions.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) intestinal ob—

stricture (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8-24-23

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) W. Boyer, M. D.

19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cemetery Woodlawn md	Aug. 27, 1923
20 UNDERTAKER	ADDRESS
George L. Schwab.	1111 Eutaw St

AUG 27 1923

mation should be carefully supplied. AGE should be stated EXACTLY. Information should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78623

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78623

CERTIFICATE OF DEATH.

X 129 ✓

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Cora Burd Phipps

(a) RESIDENCE. NO. Chambersburg, Pa ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 2 weeks yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of aug 20 1859

6 DATE OF BIRTH (month, day, and year) aug 20 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Nurse
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Shippensburg
(State or country) Pa

PARENTS

10 NAME OF FATHER Henry Rice Ruby
11 BIRTHPLACE OF FATHER (city or town) Orrstown
(State or country) Pa
12 MAIDEN NAME OF MOTHER Susan S. Ruby
13 BIRTHPLACE OF MOTHER (city or town) Fraightsville
(State or country) Pa

14 Informant Mt. Hope Retreat
(Address)

15 Filed AUG 27 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 12, 1923, to Aug 26, 1923, that I last saw h.r alive on Aug 25, 1923, and that death occurred, on the date stated above, at 7.40 A. m.

The CAUSE OF DEATH* was as follows:

Parenchymatous nephritis
Uraemic Coma

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Delusional Psychosis

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Chemical

(Signed) Milton P. Hall M. D.

19 (Address) Wyle Ave & Rockstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prest Cem Govans	aug 28 23
20 UNDERTAKER John Burns Sons	ADDRESS Govans

mation should be carefully supplied. AGE should be stated EXACTLY. If not known, it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of CAUSE OF DEATH in plain terms, so that it may be correctly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78624

HEALTH DEPARTMENT—CITY OF BALTIMORE

Daugherty

D78624

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Manhattan Ave. near Linfield Rd. ST., 27 WARD) 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Doherty

(a) RESIDENCE NO. Manhattan Ave. near Emilie Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Daugherty

6 DATE OF BIRTH (month, day, and year) July 30th 1874

7 AGE 49 Years Months 3 Days 22 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Club Steward

(b) General nature of industry, business, or establishment in which employed (or employer) Oriole Club.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Thomas Daugherty

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Mullinix

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant A. Daugherty

(Address) 916 Park Heights Ave

15 Filed AUG 27 1923 H. Russ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 24 1923.

17

I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1923, to Aug. 24, 1923, that I last saw him alive on Aug 24, 1923, and that death occurred, on the date stated above, at 5 p m.

The CAUSE OF DEATH* was as follows:

myocardial insufficiency

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Least duration uncertain about 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Alan C. Sutton M. D.

Aug 24, 1923 (Address) Old Frailes Road, Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug 28 1923
UNDERTAKER	ADDRESS
J. A. Moran	3000 E Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. Any information that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78625

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78625

CERTIFICATE OF DEATH.

127-802

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 1317 N. Carolina St. ST.; 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William H. Flynn

(a) RESIDENCE. NO. 1317 N. Carolina St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine E. Flynn

6 DATE OF BIRTH (month, day, and year) Feby 6. 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	6	9	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Insurance Agt

(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Life Ins. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Michael Flynn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eliza Coughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Catherine E. Flynn, (Address) 1317 N. Carolina

15 Filed AUG 27 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 15, 1923, to Aug 25, 1923, that I last saw him alive on Aug 25, 1923, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Hepatic Cirrhosis. Parenchymatous Nephritis (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Path.

(Signed) Jno. H. Cox, M. D.

19 (Address) 17 W. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral. Cty.	Aug 28 1923
20 UNDERTAKER	ADDRESS
J. A. Moran	300 E. Balto St.

mation should be carefully supplied. AGE should be stated IMMEDIATELY after birth. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1212-23—M&T—100 Bks.

D78626

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78626

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 N Pine St., 4 WARD)

2-FULL NAME Isabel Pourel

(a) RESIDENCE NO. 223 N Pine St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colo	Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 070
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Frank Pourel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mckrow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs. R. C. Elliott
(Address) 1725 Eastland ave

15 Filed AUG 27 1923 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/24 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~Inquest, autopsy~~ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ~~Inquest or~~ inquiry.) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. Don't Know

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) W. H. Young M. D.
(Coroner.)

8-27, 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. Laurel Cemetery	Aug 29 1923
20 UNDERTAKER	ADDRESS
Mrs. R. C. Elliott	1725 Eastland ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D78627

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78627

118-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Foos

(a) RESIDENCE NO. 2217 Canary Court ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Charles Foos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Margaret Remsche

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt

14 Informant Charles Foos

(Address) 2217 Canary Court

15 Filed AUG 27 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug. 1 , 1923 , to Aug 26 , 1923 , that I last saw her alive on Aug. 26 , 1923 and that death occurred, on the date stated above, at 1 00 P. m.

The CAUSE OF DEATH* was as follows:

General Peritonitis

Terminal Pneumonia 7 days

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

Partial (duration) yrs. 2 mos. 28 ds.

18 Where was disease contracted if not at place of death? 2217 Canary Court

Did an operation precede death? Yes Date of Aug 9, 1923

Was there an autopsy? Partial

What test confirmed diagnosis? Clinical findings-Operation

(Signed) Geo B Sybert Dept M. D.

, 19 (Address) St Joseph's Hosp

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Emily	Aug 29 1923
20 UNDERTAKER	ADDRESS
Kendall Dysart & Son	378 Mn

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78628 HEALTH DEPARTMENT—CITY OF BALTIMORE 38 D78628

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. 317 E 21 1/2 St. VA Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hallie Hicks.

(Residence in Baltimore: No. 317 E. 21 1/2 25 St.; yrs., 10 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Married

6-DATE OF BIRTH. Unknown, 1.....
(Month) (Day) (Year)

7-AGE. 31 yrs. mos. ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer). Laborer. Odd

9-BIRTHPLACE, (State or Country). Va.

PARENTS.

10-NAME OF FATHER, Edward Hicks

11-BIRTHPLACE OF FATHER, (State or Country). Va

12-MAIDEN NAME OF MOTHER, Hattie Taylor

13-BIRTHPLACE OF MOTHER, (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hattie Hicks
(Address) 317 E. 21 1/2 St.

15- Ham
Filed ..... 192..... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 25 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Autopsy or Inquest) thereon and from the evidence obtained by said Inquest, and from (Autopsy or Inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pulmonary Edema
of Heart
(Duration) ..... yrs. ..... mos. ..... ds.
CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)
Aug 26 1923 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL.
Lynchburg Va	Aug 27 1923
20-UNDERTAKER,	ADDRESS
Mrs R. C. Elliott	1725 Eutaw Pl.

N. B.—Every item of information should be carefully supplied. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

078629 90 ✓ 078629

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 E. 23rd ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milton Heathcote

(Residence in Baltimore: No. 507 E. 23rd St St.: 40 yrs., 6 mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Male	White	Widower

6-DATE OF BIRTH. October (Month) 27 (Day), 1852 (Year)

7-AGE. 71 yrs. 10 mos. 5 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer): Balto. Co. Club

9-BIRTHPLACE, (State or Country). York Co Pa.

PARENTS.

10-NAME OF FATHER. Martin Heathcote

11-BIRTHPLACE OF FATHER (State or Country). York Co Pa

12-MAIDEN NAME OF MOTHER Eliza E. Kohler

12-BIRTHPLACE OF MOTHER (State or Country). York Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. Edwin Roby

(Address) 507 E. 23rd St.

15- Filed AUG 27 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August (Month) 27 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 2 1923, to Aug 26 1923, that I saw h im alive on Aug 26 1923, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis and Endocarditis

(Duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Senile Nephritis

(Duration) yrs. 2 mos. ds.

(Signed) C. Hammond M. D.

Aug 27, 1923 (Address) 219 E. Preston St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, St Vincents — DATE OF BURIAL, Aug 29, 1923

20-UNDERTAKER E. A. Wiedefeld — ADDRESS 501 E 22 St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

078630

CERTIFICATE OF DEATH.

90 078630

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aged Women's Home ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Davis

(a) RESIDENCE No. 1400 W Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. 5 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Wht	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 28, 1847

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
76	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Charles F Davis

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Amelia Miller

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs Flora Sifkabyk
(Address) 1400 W Lexington Md

15 AUG 27 1923 GL
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1923

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to Aug 26, 1923, that I last saw h alive on Aug 26, 1923, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) 1 yrs. mos. da.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J Howard, M. D.

Aug 27 1923 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 29 1923
20 UNDERTAKER George J Smith	ADDRESS 153 Hollins

...mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78631

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78631

188-003

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond C. O'Donnell

(Residence in Baltimore: No. 1737 E. Preston St. St.; 24 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	married

6-DATE OF BIRTH. June (Month) ..... (Day) 1897 (Year)

7-AGE.	If LESS than 1 day,
26 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): (Copperworks)

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. John H. O'Donnell

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Annie T. Dolein

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Loretta O'Donnell

(Address) 1737 E. Preston St.

15-

Filed AUG 27 1923 192.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 25 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of base of skull.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) automobile accident.

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy, M. D. (Coroner.)

August 4, 1923 (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
New Cathedral	Aug. 28th 1923

20-UNDERTAKER, Robt F. Turner Inc. ADDRESS 1442 N. Broadway

N. B.—Every item of information should be given, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may state CAUSE OF DEATH in plain terms, so that it may is very important. See instructions on back of certificate.

D78632

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78632

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Josephs Hospital St. 10 Ward) 18

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Byrnes

(Residence in Baltimore: No. 721 E. Chase St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, ~~Widowed~~, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. July (Month) 8 (Day) 1848 (Year)

7-AGE. 75 yrs. 1 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of Industry, business, or establishment in which employed (or employer) None

9-BIRTHPLACE, (State or Country). Ireland

PARENTS.

10-NAME OF FATHER. Martin Magher

11-BIRTHPLACE OF FATHER, (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Mary Ryan

13-BIRTHPLACE OF MOTHER, (State or Country). Ireland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bernard D. Byrnes

(Address) 721 E. Chase St.

15- Filed ..... 192..... AUG 27 1923 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 25 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ~~his~~ death on the day stated above.

THE CAUSE OF DEATH* was as follows:

Fractured Femur

Accident (Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs.....mos.....ds.

(Signed) John J. Morrison M. D.
(Coroner.)

1923 (Address) 3611 Roland Ave

*State the Disease causing Death, or, in deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Cathedral DATE OF BURIAL. Aug 28 1923

20-UNDERTAKER. K. C. Niedefeld ADDRESS 914 Greenmt Ave

N. B.—Every item of information should be given as accurately as possible, so that it may be properly classified. Exact statement of OCCUPATION and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION and

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

~~578633~~

CERTIFICATE OF DEATH.

113 ~~578633~~

1-PLACE OF DEATH 2638 Mempeals Lane

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... St.: 70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Aurthor Allenbaugh.

(a) RESIDENCE. No. 2638 Mempeals Lane ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	— 1	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William A. Allenbaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Ida L. Mahlert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Jersey City New Jersey

14 Informant William A. Allenbaugh
(Address) 2638 Mempeals Lane.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 19 23

17 I HEREBY CERTIFY, That I attended deceased from Aug 19, 1923, to Aug 25, 1923, that I last saw h[illegible] alive on Aug 25, 1923, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) Enemia

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Asa L Bressler, M. D.

(Address) 2565 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Aug. 27 1923
20 UNDERTAKER George L. Schwab	ADDRESS 2101 Fredk ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement TION is very important. See instructions on back of certificates.

D78634

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78634

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No.) Homewood Hospe 13 168 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. William E Bull

(Residence in Baltimore: No. 703 Crisp St St.; yrs. 43 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, white

5-~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (Write the word.)

6-DATE OF BIRTH. Aug 2 1.....
(Month) (Day) (Year)

7-AGE. 43 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Engineer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. George H Bull

11-BIRTHPLACE OF FATHER, (State or Country). Md

12-MAIDEN NAME OF MOTHER. Martha Briggs

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Burns

(Address) 36th & Elm Ave

15-

Filed ..... 192.....

Robert P. Harrison
Registrar.

Burial Permit Clerk.

N. B.—Every item of information should be given as definitely as possible, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 26 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or Inquiry.) find that said deceased came to h.s death on the day stated above.

The CAUSE OF DEATH* was as follows

Strangulation
Suicide

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robt P Harrison M. D.
(Coroner.)

Aug 27 1923 (Address) 3 E Pleasant

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.
St Marys Hampden Aug 28 1923

20-UNDERTAKER. ADDRESS.
SHENOWETH & SON,
3617 CHESTNUT AVE.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78635 80 ✓ D78635

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2818 Bernard St., 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E Pittinger

(Residence in Baltimore: No. 2818 Bernard St St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F

4-COLOR OR RACE, White

5-Single, ~~Married,~~ ~~Widowed,~~ or ~~Divorced,~~ (Write the word.)

6-DATE OF BIRTH. June 6 (Month) (Day) 1922 (Year)

7-AGE, 1 yrs. 2 mos. ..... ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. John C Pittinger

11-BIRTHPLACE OF FATHER, (State or Country). Pa

12-MAIDEN NAME OF MOTHER. Bessie Runkle

13-BIRTHPLACE OF MOTHER, (State or Country). Pa

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Pittinger

(Address) 2818 Bernard st

15. AUG 27 1923 Filed ..... 192.. Robert P. Harrison, Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, ... (Month) Aug 27 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or Inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry.) find that said deceased came to death on the date stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration).....yrs.....mos.....ds.

(Signed) John H Morgan M. D. (Coroner.)

Aug 27 1923 (Address) 1092 Rolands

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

St Marys Hampden Aug 28 1923

20-UNDERTAKER. ADDRESS. CHENOWETH & SON, 3617 CHESTNUT AVE.

N. B.—Every item of information must be given, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78636

D78636

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3531 Liberty Hts Ave ST.) 15 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Anna C. Alexander.

(a) RESIDENCE. No. 3531 Liberty Hts Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 7 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	white	widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amos A. Alexander

6 DATE OF BIRTH (month, day, and year) Jan 11-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John N. Foulke.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Katharine Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant A. Logan Alexander (Address) 3531 Liberty Hgts

15 Filed AUG 27 1923, 19 Robert P. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1923, to Aug 25, 1923.

that I last saw h[illegible] alive on Aug 25, 1923.

and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows:

Paraplegia Right side Right
(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(duration) ✓ yrs. ✓ mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Usual

(Signed) George C. Shannon, M. D.

Aug 25 1923 (Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Orem. Cemetery	8/28 1923
20 UNDERTAKER	ADDRESS
L. Frew McCully	130 E. Fay

Information should be carefully supplied. Any [illegible] that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78637

D78637

101-00

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mechonienski, Constantine

(a) Residence No. Mercy Hospital St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	white	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1873

7-AGE.	If LESS than 1 day,
50 yrs. mos. ds.	hrs. or min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of Industry, business, or establishment in which employed (or employer). Pantry Man

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Lithuania

PARENTS.

10-NAME OF FATHER, Joseph Mechnienski

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Lithuania

12-MAIDEN NAME OF MOTHER, Magdaline

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Lithuania

14- (Informant) Hospital Records

(Address).....

15- Filed ..... 192.... Registrar.

AUG 27 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 25-23

17- I HEREBY CERTIFY, That I attended deceased from 8/19/23 19.... to 8/25/23 19....

that I last saw h.. alive on 8/25/23 19....

and that death occurred, on the date stated above, at 1.40 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema - Asthma - Chr. Myocarditis.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) H. W. Holley M. D.

, 19 (Address) Mercy

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL, ... 19....

20-UNDERTAKER. ADDRESS

Commissioner of Health,

Per Wm. R. WOODALL

AUG 25 1923

UNIVERSITY OF MARYLAND

Should be clearly and properly filled. Exact statement of OCCUPATION is very ... in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78638 D78638

CERTIFICATE OF DEATH.

Registered No. 6176

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tubercular Hospital St., 9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Cook

(a) Residence No. 648 All St. Near Reece St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6-DATE OF BIRTH (month, day and year)

7-AGE. 21 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer) Plasterer

(c) Name of employer Unknown

9-BIRTHPLACE (city or town) (State or Country) Virginia

PARENTS.

10-NAME OF FATHER. Wm. Henry Cook

11-BIRTHPLACE OF FATHER (city or town) (State or Country) Virginia

12-MAIDEN NAME OF MOTHER. Mary Kelly

13-BIRTHPLACE OF MOTHER (city or town) (State or Country) Virginia

14-

(Informant) Walter Cook

(Address) 648 All St.

15-

Filed ..... 19.... .....

Registrar.

AUG 27 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-23-23

17- I HEREBY CERTIFY, That I attended deceased from Aug 2 1923 to Aug 23 1923

that I last saw him alive on Aug. 23 1923

and that death occurred, on the date stated above, at 5.20 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) L. L. Lally M. D.

, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL. ....., 19....
20-UNDERTAKER.	ADDRESS
Commissioner Health.	7

Should be carefully supplied. Exact statement of OCCUPATION is very important. In plain terms, so that it may be properly classified. See instructions on back of certificates.

UNIVERSITY OF MARYLAND

D78639

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D78639

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 119 W. Hughes St., 23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Willie Tyler

(Residence in Baltimore: No. 119 W. Hughes St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Col'd	Single

6-DATE OF BIRTH. March 4th 1885
(Month) (Day) (Year)

7-AGE. 38 yrs. 5 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Md

PARENTS.

10-NAME OF FATHER. James Tyler

11-BIRTHPLACE OF FATHER. (State or Country). Md

12-MAIDEN NAME OF MOTHER. Margret Downs

13-BIRTHPLACE OF MOTHER. (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Tyler

(Address) 1718 Mount St

15-

Filed AUG 28 1923 192 G. H. Grese Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 26th 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrage of Lungs
a few minutes
after Hemorrhage
(Duration) mos.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis
(Duration) yrs. mos. ds.

(Signed) Thos. B. Morton M. D.
(Coroner)

Aug 26th 1923 (Address) Curtis Bay

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal. Pulmo. Tbc

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt. Auburn DATE OF BURIAL. Aug 28 1923

20-UNDERTAKER. James N. Davis & Son ADDRESS 1303

N. B.—Every item of information must be given, so that it may be properly classified. Exact statement of OCCUPATION state CAUSE OF DEATH in plain terms, so that is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78640

CERTIFICATE OF DEATH.

101-001 D78640

1-PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie Stokes

(a) RESIDENCE NO. 1031 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. 9 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 31st 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	7	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER Lovick Stokes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Etta Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant University Hospital Records (Address) Lombard & Green Sts.

15 Filed AUG 28 1923 C. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 26, 1923, to Aug 27, 1923, that I last saw her alive on Aug 27, 1923, and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) John M. Edmonds M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	Aug 28 1923

20 UNDERTAKER Joseph B Cook ADDRESS 1003 M[illegible]

mation should be carefully supplied. AGE should be stated CAREFULLY. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

16-002 D78641

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-002 D78641

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. REGISTERED NO.

CITY OF BALTIMORE: (No. " " " ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earle Lawrence.

(a) RESIDENCE NO. Hamilton Ave. Raspberg Md. WARD

(Usual place of abode)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced ~~HUSBAND~~ of ~~(or) WIFE of~~ Walter Lawrence (father.

6 DATE OF BIRTH (month, day, and year) May 3-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER Walter Lawrence

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Lillian ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records

15 AUG 28 1923 G. E. Cassel Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 23 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 19, 1923, to Aug 23, 1923, that I last saw him alive on Aug 23, 1923, and that death occurred, on the date stated above, at 11:00 a. m.

The CAUSE OF DEATH* was as follows:

Dysentery, Bacillary (Flexner)

(duration) — yrs. — mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Raspberg, Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Bacteriological

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lutheran Cemetery — DATE OF BURIAL Aug 28 1923

20 UNDERTAKER George S. Schilling & Sons — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78642

CERTIFICATE OF DEATH.

31 ✓ D78642

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 Ensor ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel B. Godman.

(a) RESIDENCE NO. 1505 Ensor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M. Godman.

6 DATE OF BIRTH (month, day, and year) 3/15/1890

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Paper Box Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Geo. W. Godman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Camden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. Samuel Godman

(Address) 1505 Ensor St

15 Filed AUG 28 1923 C. H. Cross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 24 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 23. 1923. to Aug 24. 1923.

that I last saw him alive on Aug 24. 1923.

and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam; history

(Signed) Jacob Cohen, M. D.

8-27 1923 (Address) 223 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL Aug. 28 1923

20 UNDERTAKER George F. Putts — ADDRESS 1735 Harford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D78643

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78643

CERTIFICATE OF DEATH.

Registered No. 6112

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tubercular Hospital St., 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Edel

(a) Residence No. Dundalk Junction St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Mrs. Geo. Edel

6-DATE OF BIRTH (month, day and year) Baltimore

7-AGE. 58 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Laborer Unknown

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, John H. Edel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Elizabeth Volant

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Mrs George Edel

(Address) Dundalk Jct

15- Filed AUG 28 1923 G. H. Crese Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 8-26-23

17- I HEREBY CERTIFY, That I attended deceased from May 12 19 23 to Aug 26 19 23

that I last saw him alive on Aug 26 19 23

and that death occurred, on the date stated above, at 5.30 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 4 mos. 8 ds.

CONTRIBUTORY (Secondary) Pulmonary Haemorrhage 42 oz. Blood lost.

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum & X-ray

(Signed) L. G. Lahey M. D

, 19 (Address) Municipal Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery DATE OF BURIAL. Aug. 29 1923

20-UNDERTAKER, George J. Ruth ADDRESS 1735 Hayford.

Should be CAREFULLY prepared. Exact statement of OCCUPATION is very important. Use in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78644

CERTIFICATE OF DEATH.

22-002

D78644

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1810 E. Monument ST.; 7 WARD)

2-FULL NAME James B. Bennett

(a) RESIDENCE No. 1810 E. Monument ST., 7 WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Ida B. Bennett

6 DATE OF BIRTH (month, day, and year): July 31 1855

7 AGE — Years: 68 — Months: — Days: 26. — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Builder

(b) General nature of industry, business, or establishment in which employed (or employer): 016

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Robert Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Elizabeth Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Eastpr. Prus. Ger.

14 Informant (Address): Ida B. Bennett 1810 E. Monument St

15 Filed ..... 19 .....

G. H. Grese Registrar

AUG 28 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): aug 26 1923

17 I HEREBY CERTIFY, That I attended deceased from aug 10 23 to aug 26 23

that I last saw him alive on aug 22 1923

and that death occurred, on the date stated above at ..... m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
Chronic Nephritis
Cirrhosis of Liver Hypertrophy
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy findings

(Signed) Fred Dupuis M. D.

, 19 (Address) 1010 Bank Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Aug 28 1923

20 UNDERTAKER: William G. Schaffer — ADDRESS: 1816 Monument

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non Alcoholic

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78645

CERTIFICATE OF DEATH.

31 ✓ D78645

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 7 W. Wylie ave ST.: 27 WARD)

2-FULL NAME Thomas Jacob Dailey

(a) RESIDENCE. NO. 7 W. Wylie Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 6 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary V. Dailey

6 DATE OF BIRTH (month, day, and year) Feb. 25 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ice Dealer 045

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 1/22.

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Thos. H. Dailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Trainer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr Louis E. Dailey

(Address) 16 Fear ave. ✓

15 Filed ..., 19...

Registrar

AUG 28 1923 G. H. Gross

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 25, 1923, to Aug. 26, 1923, that I last saw him alive on Aug. 26, 1923, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. R. Johnson M. D.

Aug. 27 (Address) 3928 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	Aug 29 1923

20 UNDERTAKER Martin Lackey & Son ADDRESS 1819 N. North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Tuberculosis

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78646

D78646

CERTIFICATE OF DEATH

1-PLACE OF DEATH Saint Agnes Hospital 117

CITY OF BALTIMORE: (No. ..... ST. 19 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss anna Healey Dowd

(a) RESIDENCE NO. 115 South Stricker Street

(Usual place of abode) ST. WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 4 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of - Michael J. Dowd Jr.

6 DATE OF BIRTH (month, day, and year) Sept 18 - 1900

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
23	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. House work. 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Daniel Healey.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ella Woulfe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pelgyd.

14 Informant Mr Michael J Healey

(Address) 115 S Stricker St

15 Filed AUG 29 1923 C. H. Gross Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug. 24, 1923, to August 26, 1923, that I last saw her alive on August 26, 1923, and that death occurred, on the date stated above, at 12.45 A. m.

The CAUSE OF DEATH* was as follows:

Peritonitis. (gangrenous appendix)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of aug. 24, 1923

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Edward H. Kalowski, M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL Aug 29 1923

20 UNDERTAKER John F. Dwyer & Son ADDRESS 901 Hollins St

per W. F. Dwyer.

mation should be carefully supplied. AGE should be given in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78647

CERTIFICATE OF DEATH.

113 D78647

1-PLACE OF DEATH University Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... St., 19 Ward)

2-FULL NAME William Emrick

(a) RESIDENCE No. 1406 Kuper St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 27 - 1923.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Emrick

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lillian Doering

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant University Hospital Records
(Address)

15 AUG 28 1923 C. H. Grese Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 14, 1923, to Aug 27, 1923, that I last saw him alive on Aug. 27, 1923, and that death occurred, on the date stated above, at 11:15 P.M.

The CAUSE OF DEATH* was as follows:

Chronic malnutrition
Acute diarrhoea

(duration) yrs. 1 1/2 mos ds.

CONTRIBUTORY (Secondary) Acute diarrhoea

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Signs + symptoms

(Signed) John M. Edmonds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	Aug 28 1923
20 UNDERTAKER	ADDRESS
Chas J. Cowan	901 Hollins St

mation should be carefully supplied. AGE should be stated EXACTLY. Ignorance of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78648

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78648

101-001

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1108 Warner ST. 21 WARD)

2-FULL NAME Elijah Thomas Smith

(a) RESIDENCE NO. 1108 Warner ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Myrtle Smith

6 DATE OF BIRTH (month, day, and year) July, 25, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	28	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver 23

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Schemmes Transfer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER James Smith

11 BIRTHPLACE OF FATHER (city or town) Alexandria (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ellen Gaines

13 BIRTHPLACE OF MOTHER (city or town) Alexandria (State or country) Virginia

14 Informant Walter Smith

(Address) 1126 Warner St

15 Filed AUG 28 1923 Hall Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1923, to Aug. 26, 1923, that I last saw him alive on Aug. 26, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) 1 yrs. 1 mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No,

What test confirmed diagnosis?

(Signed) Dan Donelan M. D.

8/27, 1923 (Address) 122 N Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Aug 29 1923
20 UNDERTAKER	ADDRESS
Mrs. R. C. Elliott	1723 Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Erasures, interlineations, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78649

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78649

74-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3411 Ash Street ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Wesley Trail

(a) RESIDENCE No. 3411 Ash St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 10 mos. 3 ds. How long in U. S., if of foreign birth? 67 yrs. 10 mos. 3 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia Louise Trail

6 DATE OF BIRTH (month, day, and year) Oct 22, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Trail

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Eliza Ricketts

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Virginia Louise Trail (Address) 3411 Ash St

AUG 28 1923

Filed ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923 to Aug 25, 1923

that I last saw him alive on Aug 25, 1923

and that death occurred, on the date stated above, at 4:20 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Pressure.

(duration) yrs. 2 mos. 25 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C F Hamilton M. D.

9/26 1923 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's, Hampden	Aug 28, 1923
20 UNDERTAKER E. LeRoy Stiffler	ADDRESS 125 E Northern

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. NAME of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78650

D78650

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

185

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. St Joseph Hospital St., 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Theodore F Stern

(Residence in Baltimore: No. 906 N Pat St St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. Aug 25th 1879 (Month) (Day) (Year)

7-AGE. 49 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Foreman
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER. Peter Stern

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Mary Maryland

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frances M Stern

(Address) 906 N Pat St

15- Filed AUG 31 1923 19?.. Hall Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Aug 25th 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows:

Fracture skull
Dye to falling down
Stairs Accidental

(Duration) .....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) ..... M. D. (Coroner.)

Aug 27 1923 (Address) 1632 Roland Ave

State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Holy Redeemer — DATE OF BURIAL, Aug 29 1923

20-UNDERTAKER. Robt F Turner — ADDRESS 1441 N Broadway

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D78651

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002

159 D78651

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 W. Cross St. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME not named (Baby Donnelly)

(a) RESIDENCE No. 1016 W. Cross ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-27-23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	—	—	—	2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Thomas Donnelly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Catherine Lusby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Catherine Lusby
(Address) 1016 W. Cross St.

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/27/ 1923

17 I HEREBY CERTIFY, That I attended deceased from 8/27, 1923, to 8/27, 1923, that I last saw h[illegible] alive on 8/27/23, 19..., and that death occurred, on the date stated above, at 7 p.m.

The CAUSE OF DEATH* was as follows:

Stillborn Premature
Ora to Cephe

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Unattended

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Stephen Donnelly, M. D.

....., 19 (Address) 1 W. Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Aug 28 1923

20 UNDERTAKER: Geo Lambach & Son — ADDRESS 647 W. Fayette St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should see that it may be properly classified. Exact statement of OCCUPATION and CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78652

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

H/ D78652

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 Collins Ave ST., 20 WARD)

2-FULL NAME John Vogelsang

(a) RESIDENCE NO. 114 Collins Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brushmaker

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frank Vogelsang

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Bierman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fred. A. Krause
(Address) 703 Hanover St

15 Filed AUG 28 1923, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26-1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 18, 1923, to Aug. 26, 1923, that I last saw him alive on Aug. 26, 1923, and that death occurred, on the date stated above, at 8.43 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach (duration) 1 yrs. mos da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Cor. Schilling, M. D.

8-28, 1923 (Address) 1120 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. DATE OF BURIAL Aug 29 1923

20 UNDERTAKER F. A. Krause & Son ADDRESS 703 Hanover St

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, that fact CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78653

CERTIFICATE OF DEATH.

90 D78653

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Chesapeake av ST., 25 WARD)

2-FULL NAME Joseph C. Jordan

(a) RESIDENCE NO. Chesapeake av ST., 25 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Jordan

6 DATE OF BIRTH (month, day, and year): January 20 - 1846

7 AGE: Years 77 Months 7 Days 7

If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Laborer 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Robert Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Minnie P. Jester

(Address): 3 Rosemont Balto city

15 Filed AUG 28 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 27 1923

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1923, to Aug 27, 1923

that I last saw h alive on Aug 26, 1923

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

Independent

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 9 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. B. Campbell (M. D.)

Aug 27 1923 (Address) 16 W Hamsworth

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Aug 29 1923

20 UNDERTAKER: George L. Schmit — ADDRESS: 2361 Bulk Av

mation should be carefully supplied. AGE should be stated EXACTLY. If infants, NAME should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78654

D78654

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE (NO. Highland Ave & Bel Ave ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles J. Arnold

(a) RESIDENCE NO 3404 E. Fair mount Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Johanna Arnold

6 DATE OF BIRTH (month, day, and year) Dec. 3rd 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	8	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer U R Tele Co

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Rudolph Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Helen Feltman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Johanna Arnold
(Address) 3404 E. Fair mount ave

15 Filed AUG 28 1923 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.), thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation, Heart
Died Suddenly

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Geo. B. Norton M. D.
(Physician or Coroner.)

Aug 26 1923 (Address) Curtis Bay

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL Aug 28 1923

20 UNDERTAKER George L. Schmidt ADDRESS 701 Fulton Ave

CAUSE OF DEATH must be properly classified. Exact statement of disease is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

(Mary Rittenhouse)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78655

CERTIFICATE OF DEATH.

161-001 D78655

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 3900 Dunall ave ST., 15 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rittenhouse

(a) RESIDENCE NO. 3900 Dunall ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 26 - 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or 1 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... NR O

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) .....

PARENTS

10 NAME OF FATHER Truman Rittenhouse

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germantown Penna

12 MAIDEN NAME OF MOTHER Mary Dillon

13 BIRTHPLACE OF MOTHER (city or town) Falmouth
(State or country) Ire

14 Informant W. E. Rittenhouse
(Address) 3900 Dunall ave

15 8 1923, 19.....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/27 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1923, to August 27, 1923, that I last saw h[illegible] alive on August 27, 1923, and that death occurred, on the date stated above, at 10:00 p.m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar, Acute,

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Influenza

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical & Physical

(Signed) Jay A. Shelley, M. D.

8/27, 1923 (Address) 1414 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Aug 28 1923

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

mation should be carefully supplied. AGE should be stated EXACTLY. Ditto marks CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU-TION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

078656

078656

CERTIFICATE OF DEATH.

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2600 Foster ave St.; 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Franklin

(Residence in Baltimore: No. 2600 Foster ave St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Sept 30, 1878
(Month) (Day) (Year)

7-AGE, 45 yrs. 11 mos. ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): 03

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Poslanak Posen

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Margaret

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mat Franklin

(Address) 2600 Foster ave

15-

Dec. 26 1923; 191.....

Registrar.

G261923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 27, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 15 1923, to Aug 27 1923, that I saw her alive on Aug 27 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Maxwell F Mazer M. D.

Aug 27, 1923 (Address) 3115 E Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Aug 29, 1923

UNDERTAKER John M Kelly

ADDRESS 1803 Bank

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

D78657

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78657

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1712 Madison Ave. St., 14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME.... Louis Allen

(Residence in Baltimore: No. 1509 Madison Ave. St.; yrs., 3 mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	married

6-DATE OF BIRTH. about 1897
(Month) (Day) (Year)

7-AGE. 26 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Structural
(b) General nature of industry, business, or establishment in which employed (or employer)..... Iron worker 074

9-BIRTHPLACE, (State or Country), S. Carolina

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country), Unknown

12-MAIDEN NAME OF MOTHER, Mrs. Sallie Williams

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) N. W. Dist. Police

(Address) Penna. Ave.

15- AUG 28 1923 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 26, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy & T.K. D.T. Anthony (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy & T.K. (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun shot wounds in chest.

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Homicide

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. T. Hennessy M. D.
(Coroner.)

August 27 1923 (Address) 1502 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Chester, S. Car.	8-29-23

20-UNDERTAKER	ADDRESS
Geo. J. Ruth	1735 Harford Ave

N. B.—Every one of the above items must be properly filled. Exact statement of OCCUPATION and state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78658 D78658

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 614 N. Bond ST., 7 WARD)

Earl Lewis

2-FULL NAME Earl Lewis

(a) RESIDENCE No 614 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
~~5 HOURS~~	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Wm White

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Julia Lewis

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Julia Lewis
(Address) 614 N Carlton

15 Report received Aug 28 1923

Registrar

AUG 28 1923

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Entered Orifice

about 3 days or more (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Riley, M. D.
(Coroner.)

Aug 28, 1923 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	8/28 1923

20 UNDERTAKER R. C. Gross 1405 N. Caroline st

CAUSE OF DEATH must be stated plainly, so that a definite opinion may be formed as to the cause of death. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D78659

HEALTH DEPARTMENT—CITY OF BALTIMORE

36-002 D78659

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1101 N Patterson Pk Ave (WARD) 8

2-FULL NAME James Kubant

(a) RESIDENCE NO. 1101 N Patterson Pk Ave (WARD) 8

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Frances Kubant

6 DATE OF BIRTH (month, day, and year): Sep. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: John Kubant

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Frances Fic

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant (Address): Frances Kubant 1101 N Patterson Pk Ave

15 Filed AUG 28 1923 .19 Robert J Morrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 17, 1923, to Aug 27, 1923, that I last saw him alive on Aug 2 19 and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis of sacrum & ileac bones.

(duration) 21 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) Joseph Potkanicz M. D.

. 19 (Address) 2124 Ashland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: Aug 29, 23

20 UNDERTAKER: Chas. H. Fink & Son, Funeral Directors & Embalmers.

ADDRESS: 511 N Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Tubercular

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78660

CERTIFICATE OF DEATH.

113 D78660

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2019 Booth St ST., 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cecelia Lafferty

(a) RESIDENCE NO. 2019 Booth St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 25 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
			2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Robt Lafferty

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Anna Stekinger

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Robt Lafferty
(Address) 2019 Booth St

15 ..... 192 .....
Registrar

G281923

Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Don't Know

..... (duration) ..... yrs. ..... mos. ..... ds.

(Signed) H H Greene M. D.
(Coroner.)

Aug 28, 1923 (Address) 117 W Saratoga

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 28 1923

20 UNDERTAKER George A. [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D78661

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78661

CERTIFICATE OF DEATH.

Registered No. .....

1-PLACE OF DEATH
City of BALTIMORE: (No. 1420 Hull St. St., 24 Ward)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J Smith.

(a) Residence No. 1420 Hull St. St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie G. Smith

6-DATE OF BIRTH (month, day and year) Nov. 20. 1894

7-AGE. 28 yrs. 9 mos. 8 ds. | If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Dock Builder
(b) General nature of industry, business, or establishment in which employed (or employer) Balto Dry Dock Co
(c) Name of employer .....

9-BIRTHPLACE (city or town) Ireland
(State or Country),

PARENTS.

10-NAME OF FATHER, Chas. J Smith
11-BIRTHPLACE OF FATHER (city or town) Ireland.
(State or Country),
12-MAIDEN NAME OF MOTHER, Not known
13-BIRTHPLACE OF MOTHER (city or town) Ireland
(State or Country).

14- (Informant) Bessie G Smith
(Address) 1420 Hull St.

15- Filed ..... 192..... Registrar.

AUG 28 1923 Joseph F. Harrison
Deputy Health Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 28. 23.

17- I HEREBY CERTIFY, That I attended deceased from June 28 19 23 to Aug 28 19 23
that I last saw h.. alive on Aug 27 19 23
and that death occurred, on the date stated above, at 12 30 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonary Tuberculosis

(Duration) ..... yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? No. Date of .....
Did an operation precede death? No.
Was there an autopsy? None.
What test confirmed diagnosis? None. M. D
(Signed) Thos. F. Simons
8/28. 1923 (Address) 2878 Harford Rd

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cathedral Cem. | DATE OF BURIAL. 8—31, 1923

20-UNDERTAKER. Charles L. Stevens | ADDRESS 1500 Eastern Ave

Spec—12-23-21—E.B.R.S.—400 Bks. should be carefully supplied. AGE should be stated EXACTLY. Impossible or improbable ages will be rejected. Exact statement of OCCUPATION is necessary that it may be properly classified. In plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78662

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D78662

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2732 Pennsylvania ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Missouri Myers

(a) RESIDENCE NO. 2732 Pennsylvania ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Female~~

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): January 1866

7 AGE: Years 57 Months 7 Days 22 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer): 069

(c) Name of employer: McCauley & Co Carriage Co Md

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Johnny Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co Md

12 MAIDEN NAME OF MOTHER: Susan Wolf

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. O. W. Cruett

(Address) 2732 Penna Ave

AUG 28 1923

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 27 1923

17 I HEREBY CERTIFY, That I attended deceased from 8/1—, 1922 to 8/27, 1923, that I last saw h— alive on 8/24, 1923, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

Signed: W. Thos Bryant, M. D.

8/28, 1923 (Address) 1924 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Manchester Md — DATE OF BURIAL: Aug 29 1923

20 UNDERTAKER: H. J. Tucker & Sons — ADDRESS: Manchester

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78663

CERTIFICATE OF DEATH.

113

D78663

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 473 Augusta Ave ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph F Holtman

(a) RESIDENCE NO. 473 Augusta Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 30 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm E Holtman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Agnes Staiger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs Agnes Holtman

(Address): 473 Augusta Ave

Filed ..... 19 ..... Robert F. Carrick, Registrar

Burial Permit Clerk.

UG 28 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 19 1923 to Aug 26 1923, that I last saw h— alive on Aug 26 1923, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Ac Gastro Enteritis

(duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) H. A Knell M. D.

(Address) Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 8/29/23

20 UNDERTAKER: George A Tinley — ADDRESS: Fulton Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78664

CERTIFICATE OF DEATH.

74 001 V

74 D78664

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 27 N. Gorman Ave ST. 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Francis Ewalt

(a) RESIDENCE. No. 27 N. Gorman Ave ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Ewalt

6 DATE OF BIRTH (month, day, and year): Aug 31 1860

7 AGE — Years: 62 Months: 11 Days: 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): City Fire Dept

(c) Name of employer: Balto. City Fire Dept

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Ferdinand Ewalt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Degan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wm J Ewalt

(Address): 3514 Chestnut Ave

15 Filed 19 Robert P. Harrison, Registrar

AUG 28 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 25th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 18th, 1923, to Aug. 25th, 1923, that I last saw him alive on Aug. 25th, 1923, and that death occurred, on the date stated above, at 8.45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 7 da.

CONTRIBUTORY (Secondary), Chr. Interstitial Nephritis; Toxic Hypertension, (duration) 15 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) D. Edgar Fay, M. D.

8/25, 1923 (Address) 2919 Belmont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	8/29/23

20 UNDERTAKER: Geo A Fahey Sulton & Fayette ADDRESS

N. B. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78665

CERTIFICATE OF DEATH.

74-001 D78665

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6000 Bellona Av 27 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William S. Renshaw.

(a) RESIDENCE NO. 3012 Guilford Av ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 7 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced~~, (write the word)
Male	White	Single

5a If married, widowed, or divorced (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) January 23/1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	58	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer) 09

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm B. Renshaw

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md

12 MAIDEN NAME OF MOTHER Margaret Goldey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna

14 Informant J. J. Bohannan (Address) 3012 Guilford Ave

15 8-27 1923 Robert P. Watson, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1923

17 I HEREBY CERTIFY, That I attended deceased from May-1 1923 to Aug-27 1923.

that I last saw him alive on Aug-26 1923,

and that death occurred, on the date stated above, at 640 A m.

The CAUSE OF DEATH* was as follows:

Arteio Sclerosis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemmhage

(duration) yrs. mos. 7 ds

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H C Hees, M. D.

(Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL AUG 29 1923

20 UNDERTAKER Geo W Little

ADDRESS 2760 EDMONDSON AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS and CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78666

CERTIFICATE OF DEATH.

129 D78666

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 N. Fulton St. 19 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Monison

(a) RESIDENCE. No. 223 N. Fulton ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~ (write the word): Married

5a If married, ~~widowed, or divorced~~ (or) WIFE of: Daniel L. Monison

6 DATE OF BIRTH (month, day, and year): Feb 12 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Dennis M. Driscoll

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Annie McGovern

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant (Address): Daniel L. Monison 223 N. Fulton Ave

15 Filed ... 19... Registrar

AUG 28 1923

Chief Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): AUG 28 1923

17

I HEREBY CERTIFY, That I attended deceased from June 9, 1923, to Aug 28, 1923, that I last saw h[illegible] alive on Aug 27, 1923, and that death occurred, on the date stated above, at 5 40 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Myocarditis Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) James F. Bosley M. D.

AUG 28 1923 (Address) 1729 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION~~ OR REMOVAL: New Cathedral — DATE OF BURIAL: AUG 31 1923

20 UNDERTAKER: Geo N. Little — ADDRESS 2700 EDMONDSON AVE.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78667

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D78667

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 N. Mount St. ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Colvin

(a) RESIDENCE NO. 309 N. Mount Street. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 Yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Colvin

6 DATE OF BIRTH (month, day, and year) 11, 10, 1869 (1869)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) Blacksmith

(c) Name of employer Daniel Lrnord

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Charles Colvin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mary Colvin

(Address) 309 N. Mount Street.

15 Filed AUG 29 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/26.'23 19

17 I HEREBY CERTIFY, That I attended deceased from July 1st. 1923, 19 to 8/26/'23, 19, that I last saw him alive on Aug. 26th. 1923, 19, and that death occurred, on the date stated above, at 6:50 p. m.

The CAUSE OF DEATH* was as follows:

Mitral Ins.

(duration) 1 yrs. 9 mos ds.

CONTRIBUTORY (Secondary) tis Ch. Interstitial Nephrit

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urinalysis and Physical Exam.

(Signed) Walter J. Jackson M. D.

, 19 (Address) 1618 W. Mulberry Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 8/29, 19 23

20 UNDERTAKER James H. Dennis

ADDRESS 1303 Pleasant

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78668 111-002 D78668

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 12 N. Highland Ave St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Sims

(a) Residence No. 12 N. Highland St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John W. Sims

6-DATE OF BIRTH (month, day and year) Aug. 16-1875

7-AGE, 48 yrs. ... mos. 11 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work At home 037
(b) General nature of industry, business, or establishment in which employed (or employer).....
(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto. Md

PARENTS.
10-NAME OF FATHER, Wm. T. Nicholl
11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md
12-MAIDEN NAME OF MOTHER, Ellen Meads
13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto. Md

14-(Informant) John W. Sims
(Address) Fullerton, Balto. Co., Md.

15-Filed AUG 29 1923 [illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 27-1923

17- I HEREBY CERTIFY, That I attended deceased from Aug 26th. 1923 to Aug 27th. 1923
that I last saw h[illegible] alive on Aug 27th. 1923
and that death occurred, on the date stated above, at 7.15 P. m.
The CAUSE OF DEATH* was as follows:
Peritonitis due to Duodenal Ulcer perforation

(Duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Duodenal Ulcer about
Force Factory (Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? None

(Signed) D.U. Jones, M. D.
8/28/1923 (Address) 1011 N. Ellwood Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Parkwood — DATE OF BURIAL, Aug 30, 1923

20-UNDERTAKER, Winkler & Winkler — ADDRESS 1739 Eager

Should be carefully supplied. Exact statement of OCCUPATION is important. See instructions on back of certificates. — in plain terms, so that it may be properly classified.

KODAK S.A.F.

Spec.—1-10-21—M&T—1500 Bks.

D78669

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78669

118-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Adelaide Steinman

(a) RESIDENCE No. 205 So Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (write the word) ~~Married~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Leo Finley

(Address) 205 So Mount St

15 Filed AUG 29 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 27, 1923, to Aug. 28, 1923.

that I last saw h[illegible] alive on Aug 28, 1923

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

myocarditis,

Toxaemia (strangulated hernia)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of aug 27, 1923

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Edward A. Kotlowski, M. D.

, 19 Address St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetary DATE OF BURIAL Aug 30 23

20 UNDERTAKER Knell & Son ADDRESS 1097 W Pratt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S NAME and
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D78670

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001 D78670

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 W. Clement St. ST. 24 WARD)

2-FULL NAME Katharine M. Parson

(a) RESIDENCE NO. 121 W. Clement St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 19 1923

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
		10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Robert G. W. Parson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Elsie Gallaway

13 BIRTHPLACE OF MOTHER (city or town) Pa.
(State or country)

14 Informant Mrs. Robert Parson
(Address) 121 W. Clement St

15 Filed AUG 29 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28/23

17 I HEREBY CERTIFY, That I attended deceased from Aug 19/23, 19..., to Aug 28/23, 19...,
that I last saw her alive on Aug 28/23, 19...,
and that death occurred, on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:

Pernicious Hypotension

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis / Nephritis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos B Holly, M. D.

Aug 28/23 (Address) 1703 Eight

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	8/29 1923
20 UNDERTAKER D. Frew McCully	ADDRESS 1306 Ford.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must see that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78671 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓D78671

CERTIFICATE OF DEATH. 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2819 6 Clifton Ave ST., 15 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eleanor Taylor Tormey

(a) RESIDENCE NO. 2819 6 Clifton Ave ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 7 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Nov. 28-1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	25	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER J. Lee Tormey

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Nellie Allen

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant J. Lee Tormey (Address) 2819 6 Clifton Ave

15 AUG 29 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 26, 1923. to Aug. 27, 1923.
that I last saw her alive on Aug. 27, 1923.
and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia.
Myocardial Insuff.

(duration) yrs. mos 4 da.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis
(duration) 15 yrs. mos. da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? X ray - Sputum

(Signed) Joseph William Kelly, M. D.

19 (Address) 910 Brooks Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Aug 29 1923
20 UNDERTAKER Wm. J. Luckner & Sons	ADDRESS N. Y. Pa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78672

CERTIFICATE OF DEATH.

57 D78672

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1144 N Stricker ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary J. Thomas

(Residence in Baltimore: No. 1142 N. Stricker St.; 51 yrs.. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Col

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Jan 28, 1872 (Month) (Day) (Year)

7-AGE, 51 yrs. — mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... at home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country) Cambridge Md

PARENTS.

10-NAME OF FATHER, John Hall

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Thomas

(Address) 1144 Stricker St

15-

Filed AUG 29 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 28 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 2 1923, to Aug 28 1923, that I saw her alive on Aug 27 1923, and that death occurred, on the date stated above, at 2 p. m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

Diabetes Mellitus

(Duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis and Mitral insufficiency

(Duration) yrs. mos. ds.

(Signed) R J Young M. D.

8/29, 1923. (Address) 1142 E. Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Cambridge Md

DATE OF BURIAL. Aug 30, 1923

20-UNDERTAKER Geo T A Gibson

ADDRESS 513 Lanvale St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D78673 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78673

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH Hospital for the Women of Maryland

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lafayette & John ST. 13 WARD)

2-FULL NAME Baby Gordin

(a) RESIDENCE NO. 2224 Callow Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) August 28, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or 45 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — 500

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

PARENTS

9 BIRTHPLACE (city or town) Woman's Hospital
(State or country) Balto. Md.

10 NAME OF FATHER Morris Gordin

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Levin

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mr. Morris Gordin
(Address) 2224 Callow Ave —

15 Filed AUG 29 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 28, 1923

17 I HEREBY CERTIFY, That I attended deceased from 8.45 P.M. Aug. 28, 1923, to 9.30 P.M. Aug 28, 1923, that I last saw him alive on Aug. 28, 1923, and that death occurred, on the date stated above, at 9.30 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination

(Signed) J. Ogle Warfield, Jr. M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Washington Road	Aug 29 '23
20 UNDERTAKER	ADDRESS 427 E Balto St
S. Levinson & Bro.	

N.B. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are urged to note that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.--8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78674 46 D78674

CERTIFICATE OF DEATH.

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1040 Edmondson Ave. St.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME (Agnes Pogue Stevens)

(Residence in Baltimore: No. 1040 Edmondson Ave St.; 70 yrs., 9 mos. 4 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female | 4-COLOR OR RACE, White | 5-SINGLE, MARRIED, WIDOWED OR DIVORCED, (Write the word.) Married

6-DATE OF BIRTH, Nov. 24, 1852 (Month) (Day) (Year)

7-AGE, 70 yrs. 9 mos. 4 ds. | If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Frank Johnston

11-BIRTHPLACE OF FATHER (State or Country), England

12-MAIDEN NAME OF MOTHER Mary A. Lyons

13-BIRTHPLACE OF MOTHER (State or Country), Balto Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt S. Stevens

(Address) 1040 Edmondson Ave

15- Filed AUG 29 1923, 19.... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 28, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept. 1 1922, to Aug 28 1923, that I saw her alive on Aug 28 1923, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Cervix of Uterus.

.....

.....

..... (Duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Evans M. D.

8/29/23, 191... (Address) 809 Cathedral St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge | DATE OF BURIAL, Aug 30, 1923

20-UNDERTAKER Robt S. Stille | ADDRESS 2 Edmondson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

D78675

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78675

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 5938

City of BALTIMORE: (No. Municipal Tubercular Hospital 5 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ernestine Jernigan

(a) Residence No. 428 N Central Ave. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced, (Write the word.)
Female	Colored	Single

5a-If married, widowed, or divorced HUSBAND or WIFE of Single

6-DATE OF BIRTH (month, day and year) [illegible]

7-AGE. 11 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. School -girl

(b) General nature of industry, business, or establishment in which employed (or employer). School Girl

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Norfolk Va.

PARENTS.

10-NAME OF FATHER. Ulysses Jernigan

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Virginia

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

14- (Informant) Hospital Records

(Address)

15- Filed AUG 29 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8-27-23

17- I HEREBY CERTIFY, That I attended deceased from Oct 27 1922 to Aug 27 1923

that I last saw her alive on Aug 27 1923

and that death occurred, on the date stated above, at 3.00 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum & X-ray

(Signed) L. A. Tally M. D.

, 19 (Address) Municipal T.B. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL.
Evergreen Cem	Aug. 30. 1923
20-UNDERTAKER.	ADDRESS
Mrs J. G. Locke	1302 Jefferson

according to Hosp. Records.

should be carefully supplied. AGE should be stated EXACTLY. Physicians and Midwives are requested to use every effort to have this certificate filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78676

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78676

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1424 E. Lexington St. 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John McElwin

(Residence in Baltimore: No. 1424 E. Lexington St 5 St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male.	Colored	Single

6-DATE OF BIRTH. July 15 1899
(Month) (Day) (Year)

7-AGE, 24 yrs. 1 mos. 11 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Day. labor
(b) General nature of industry, business, or establishment in which employed (or employer)..... 040

9-BIRTHPLACE, (State or Country), Laxster S. C.

PARENTS.

10-NAME OF FATHER, Charlie Mcelwin

11-BIRTHPLACE OF FATHER, (State or Country) Laxster. S. C.

12-MAIDEN NAME OF MOTHER, Hattie Gambel

13-BIRTHPLACE OF MOTHER, (State or Country) Laxster S. C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lilian Young

(Address) 1424 E. Lexington St.

15- AUG 29 1923 G G Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, aug 26th 1923.
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry,) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h.... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonar Disease of Heart

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner.)

aug 27 1923 (Address) 363 E Roland

*State the Disease Causing Death, or, In deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, DATE OF BURIAL.
Asbury Cemetery aug 29th 1923

20-UNDERTAKER, ADDRESS
Milton Davis 315 N Eden St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Any error may state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78677

CERTIFICATE OF DEATH.

D78677

36

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Colonial Hosp ST., 3 WARD)

2-FULL NAME Mr - Frank OSTASZ

(a) RESIDENCE No. 258½ S Dallas ST. WARD

(Usual place of abode)

Length of residence in city or town where died occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? 20 yrs. 0 mos. 0 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary. Ostasz

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Miner

(b) General nature of Industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant N. Evdosniff (Address) 258½ S. Dallas

15 Filed AUG 29 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 9/ 1923, to Aug 27/ 1923, that I last saw him alive on Aug. 27/ 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Kidney.

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) ____ yrs. ____ mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) A. E. Rytina M. D.

8/27. 1923 (Address) 1122 N. Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	8/30 1923
UNDERTAKER	ADDRESS
Williams Funeral Home	1618 Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78678

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002 D78678

CERTIFICATE OF DEATH.

1-PLACE OF DEATH
CITY OF BALTIMORE: (No.) St Josephs Hospital ST., 4 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leroy. Jones.

(a) RESIDENCE NO. 736 Saratoga ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.
4 COLOR OR RACE: Colored.
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 3rd 1897

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
25	10	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Stevedore
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kent Co. Md.

PARENTS
10 NAME OF FATHER: Lewis Jones
11 BIRTHPLACE OF FATHER (city or town) (State or country): Kent Co. Md
12 MAIDEN NAME OF MOTHER: Ida Colton
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent Co. Md.

14 Informant: Lewis Jones
(Address): Kent Co. Md.

15 Filed AUG 29 1923 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 27, 1923., to Aug 28, 1923.
that I last saw him alive on Aug 28, 1923.
and that death occurred, on the date stated above, at 8 25 a m.
The CAUSE OF DEATH* was as follows: Cerebral hemorrhage.

(duration) yrs. mos. The
CONTRIBUTORY (Secondary) Intestinal obstruction
(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of Aug 27 '23.
Was there an autopsy? No.
What test confirmed diagnosis? P.S.I.S. + Operation
(Signed) Harold C. Pillsbury M. D.
, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chestertown, Kent Co. Md	8/29 1923
20 UNDERTAKER	ADDRESS
R. C. Gross	1733 N. Eden St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

(See Letter attached)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78679

CERTIFICATE OF DEATH.

D78679

Benjamin Pallman

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 22 WARD)

REGISTERED NO. 51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Butts or Benja. Pallman

(a) RESIDENCE NO. 87 E. Lee ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 12-1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 140

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Connecticut

PARENTS

10 NAME OF FATHER Joseph Pallman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn.

12 MAIDEN NAME OF MOTHER Maria Wang

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Conn.

14 Informant Municipal Hospital Records (Address)

15 Filed AUG 29 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27 1923

17

I HEREBY CERTIFY, That I attended deceased from June 11, 1923, to Aug. 27, 1923.

that I last saw him alive on Aug 27, 1923

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

Rheumatic Myocarditis

Myocardial degeneration

(duration) yrs. 2 mos. (4 days)

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude A. Pierce, M. D.

8-27, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Haven Conn	Aug 29 1923
20 UNDERTAKER	ADDRESS
Harry W. Ehlen	W. North Ave

N. B.—WRITE PLAINLY, WITH LINEN MARKING INK. PHYSICIANS should be careful that the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DEPARTMENT OF CHARITIES AND CORRECTIONS
SUB-DEPARTMENT
SUPERVISORS OF CITY CHARITIES

GEORGE R. McCLEARY,
SUPERINTENDENT
W. H. CURRY,
ASST. SUPERINTENDENT

CITY OF BALTIMORE
MARYLAND
MUNICIPAL DEPARTMENTS

BAY VIEW HOSPITAL
HIGHLANDTOWN P. O.

Aug. 29, 1923.

Dr. C. Hampden Jones,
Commissioner of Health,
City.

My dear Dr. Jones:-

We had a death occur at this hospital on Aug. 27th of a person, who on admission gave the name of Harry Butts, birthplace Conn., aged 34. He gave us as reference the name of Mrs. Rose Lewis 557 Dixie Ave., New Haven, Conn.

Mrs. Lewis was notified at the time of his death and her husband, E. Harry Lewis, on his arrival in Baltimore, identified the patient as Benjamin Pallman and states that this man has travel under an assumed name.

Mr. Lewis is desirous of having the record changed to the proper name and I am referring him to your office with this information.

Very truly yours,

George R. McCleary

Supt.

GRM/BG

Spec.—1-10-21—MAT—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 159-002 D78680

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. " " " ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jewell S. Burns.

(a) RESIDENCE No. Montgomery Co, Md. R.F.D. Route #1, ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Wife of Cora Burns (Parents).

6 DATE OF BIRTH (month, day, and year) June 16, 1923.

7 AGE: Years —; Months 2; Days 12. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland.

PARENTS

10 NAME OF FATHER: Wm. H. Burns.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Cora Watkins.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: JOHNS HOPKINS HOSPITAL Records. (Address)

15 AUG 29 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1923, to Aug 28, 1923, that I last saw him alive on Aug 28, 1923, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation of Heart (Pulmonary Stenosis.

(duration) yrs. Life mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Horton Casparis M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bethesda Cemetery Brookeville Md. — DATE OF BURIAL: Aug 29 1923

20 UNDERTAKER: Neal W. Starr — ADDRESS: Ellicott City Md.

AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78681

CERTIFICATE OF DEATH.

3/ D78681

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 S. Lakewood Ave. WARD)

2-FULL NAME Margaret B. Lang

(a) RESIDENCE NO. 532 S. Lakewood Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 31- 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	17	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Typiest for

(b) General nature of industry, business, or establishment in which employed (or employer) Hutzler Bros.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Alphons J. Lang

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Agnes Rhode

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Alphons J. Lang
(Address) 532 S. Lakewood Ave

15 AUG 29 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1923, to Aug 28, 1923, that I last saw him alive on Aug 24, 1923, and that death occurred, on the date stated above, at 12 40 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. L. Lap M. D.

Aug. 29, 1923 (Address) 1701 Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Aug 31 1923
20 UNDERTAKER	ADDRESS
H. Sander & Sons	1710 Fleet St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be stated EXACTLY. PHYSICIAN should be carefully supplied. AGE should be stated at it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78682

CERTIFICATE OF DEATH.

84 D78682

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 4005 Kathland ave ST., 15 WARD)

2-FULL NAME Evelyn Roberta Phyllis Dechelman

(a) RESIDENCE NO. 4005 Kathland ave WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7/6/22

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None yrs

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Benj A. Dechelmeyer

11 BIRTHPLACE OF FATHER (city or town) Balto, Md
(State or country)

12 MAIDEN NAME OF MOTHER Jennie Perkins

13 BIRTHPLACE OF MOTHER (city or town) Geneva
(State or country)

14 Informant Father
(Address)

15 Filed AUG 29 1923 [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/29 1923

17 I HEREBY CERTIFY, That I attended deceased from July 8th, 1922 to 8/29, 1923

that I last saw her alive on 8/29, 1923,

and that death occurred, on the date stated above, at 8.55 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(During birth)
(duration) yrs. mos. days

CONTRIBUTORY (Secondary) Terminal Pneumonia
of a few hours (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of —

Was there an autopsy? Partial

What test confirmed diagnosis?

(Signed) Charles Bagley M. D.

, 19 (Address) Latrobe apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holsen Kessing Rm — DATE OF BURIAL 8/29 1923

20 UNDERTAKER Jack Lewis 1439 Edmondson Ave — ADDRESS

N. B.—WHITE PENCIL, when supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Amaurotic Family
Idiocy

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78683

CERTIFICATE OF DEATH.

44 D78683

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2834 Elliott ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Kallinian

(a) RESIDENCE NO. 2834 Elliott ST., 1 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Jacob Kallinian

6 DATE OF BIRTH (month, day, and year) Dec 21 1847 50

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Not Known.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Otty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Geo. Hornay.

(Address) 3035 Eastern Ave

15 Filed AUG 29 1923 19 Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27 1923

17 I HEREBY CERTIFY, That I attended deceased from August 25 1923 to August 27 1923 that I last saw h[illegible] alive on August 27 1923 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma Larynx

(duration) yrs. 6 mos da. May [illegible]

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? V

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Caleb V Otten, M. D.

Aug. 27 1923 (Address) 100 S Patterson Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Aug 30 1923
20 UNDERTAKER	ADDRESS
Lilly & Zeiler	4003 Wolfe St

N. B. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should be careful so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are required by State law to report CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78684

CERTIFICATE OF DEATH.

90 D78684

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 3609 Sycamore Av. ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William H. Buffington

(Residence in Baltimore: No. 3609 Sycamore Av. St. 59 yrs., — mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
Male	White	Widower

6-DATE OF BIRTH, July 1, 1854
(Month) (Day) (Year)

7-AGE, 69 yrs. 1 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Balty. Co. Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country), Unknown

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Cora C. Fisher

(Address) 3609 Sycamore Av.

15- Filed Aug 31, 1923, 191.....
Robert P. Harrison, Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 28, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest and Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Disease of Heart

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary).....

(Duration).....yrs.....mos.....ds.

(Signed) John H. Morrison M. D.
(Coroner.)

Aug 29 1923 (Address) 5632 Roland Av

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, St Mary's Hampden — DATE OF BURIAL, Aug 31, 1923

20-UNDERTAKER, Harad H. Burgee — ADDRESS 563 Hollins Rd.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78685

CERTIFICATE OF DEATH.

129 D78685

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 3658 Falls Road ST., 13 WARD)

2-FULL NAME Anna M. Meehan

(a) RESIDENCE NO. 3658 Falls Road ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 2-1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) 668

(c) Name of employer Howard Co.

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER Cornelius L. Meehan

11 BIRTHPLACE OF FATHER (city or town) New Orleans La.

(State or country)

12 MAIDEN NAME OF MOTHER Mary A Phillips

13 BIRTHPLACE OF MOTHER (city or town) Virginia

(State or country)

14 Informant Cornelius L. Meehan

(Address) 3658 Falls Road.

15 Filed AUG 29 1923 . 19 Robert P. Morrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 16 , 1923 , to Aug 27 , 1923 .

that I last saw h— alive on Aug 27 , 1923 ,

and that death occurred, on the date stated above, at 3 45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) ... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? ... Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Flora C. Clark M. D.

Aug 29 1923 (Address) La Roche Apts Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Aug. 30 1923.
20 UNDERTAKER Horace F. Burgee	ADDRESS 363 Falls Road

DUPLICATE

...ATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S ... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D78686

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78686

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 129

City of BALTIMORE: (No. 1005 S. Boulding St., N Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Anna R. Kiefer

(a) Residence No. 1005 S. Boulding St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Kiefer

6-DATE OF BIRTH (month, day and year) April 5-1851.

7-AGE, 72 yrs. 4 mos. 22 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. At home

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Balto., Md.

PARENTS.

10-NAME OF FATHER, Simon Boehm

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Eva Helm.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Louis Keifer

(Address) 1005 S. Boulden St.

15- [illegible] P. Garrison, 19?

Registrar.

AUG 29 1923

[illegible] Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug. 27-'23

17- I HEREBY CERTIFY, That I attended deceased from Aug 15, 1923 to Aug 27, 1923

that I last saw h[illegible] alive on Aug 27 1923

and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Joseph Pokorny M. D.

, 19 (Address) 2124 Ashland Ave.

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Oakland Cem. DATE OF BURIAL. Aug 31 1923

20-UNDERTAKER. Zirkler & Zirkler ADDRESS 1739 E. Eager St.

should be carefully supplied. AGE should be stated EXACTLY. PERSONAL and MEDICAL particulars should be carefully supplied. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78687

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D78687

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. Municipal Hospital St., No WARD)

2-FULL NAME Henry Brandenburg

(a) RESIDENCE NO. Laurel, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed ..... 19 ..... Registrar

AUG 29 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 26 1923

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1923, to Aug. 26, 1923, that I last saw him alive on Aug. 26, 1923, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (Degenerative Myocardial Insufficiency

(duration) yrs. 4 mos (thirty) ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude G. Wood, M. D.

8-26 1923 Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner of Health

ADDRESS AUG 24 1923

N. B.—WRITE LEGIBLY. Use only black ink. All questions must be answered. AGE should be stated EXACTLY. PHYSICIAN should state mation should be carefuliy supplied. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Size 6-9-12 H. P. Co. 1000 Blks.

D78688

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78688

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Elizabeths Home ST.: 9 WARD)

REGISTERED NO. 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius Jerome Ward

(a) RESIDENCE. NO. St. Elizabeths Home Chestnut Hill and ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	negroe	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jun 6. 23

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Conshohocken
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Helen Ward

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed [illegible], 19
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 28 1923

17

I HEREBY CERTIFY, That I attended deceased from August 22, 1923, to August 28, 1923, that I last saw h[illegible] alive on August 28, 1923, and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Measles

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd, M. D.

Aug 28, 1923 (Address) 2005 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN and Nurse CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificates.

[illegible] 1923

Spec—12-23-21—E.B.R.S.—400 Bks.

D78689 **HEALTH DEPARTMENT—CITY OF BALTIMORE** 161-001 D78689

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 607 Greenmeadow St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Hopkins

(a) Residence No. 607 Greenmeadow St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	Col	

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Aug 27-23

7-AGE.	If LESS than 1 day,
0 yrs. Aug mos. 27 ds.	16 hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Oliver Hopkins

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Ethel M Anderson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14- (Informant)

(Address)

15- Filed ... 19... Registrar.

Agnes P. Harrison

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 27, 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug 27, 1923 to Aug 27, 1923

that I last saw him alive on Aug 27, 1923

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Premature birth (7 months)

16 hrs

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. C. Casey M. D.

, 19 (Address) 1032 Brady St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL,	DATE OF BURIAL, Aug 28 1923
20-UNDERTAKER,	ADDRESS

Commissioner Health,

JOHNS HOPKINS HOSPITAL

should be carefully supplied. AGE should be stated EXACTLY. Physicians should state cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78690

CERTIFICATE OF DEATH.

101-001 D78690

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 Bruntst St.: 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Bailey

(a) RESIDENCE. NO. 1319 Brunt St ST., WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or ~~WIFE~~ of) Agnes Bailey

6 DATE OF BIRTH (month, day, and year) Oct. 15-1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
50	Years	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) Dick & Shoop

(c) Name of employer John Boyle Balto Md

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Richard Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Mathews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Agnes Bailey 1319 Brunt St

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 24th 1923 to Aug 27th 1923.

that I last saw him alive on Aug 26th 1923.

and that death occurred, on the date stated above, at 5:15 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
moderate drinker

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) He had been sick

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Z. B. Ewald, M. D.

, 19 (Address) 411 N Eut

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: Aug 30 1923

20 UNDERTAKER Jno. M. Johnson — ADDRESS 1309 Druid Hill Ave

629123

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D78691

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78691

REGISTERED NO. 7400

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1058 N Bath ST., 18 WARD)

2-FULL NAME John F. Schaffer

(a) RESIDENCE NO. 1058 N Bath St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. - 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Berks Cnty
(State or country)

PARENTS

10 NAME OF FATHER Jacob Schaffer

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Mary Renn

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Geo. Foerderer
(Address) 2178 E. Pratt St

15 Filed ....., ..., 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-27 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, ~~autopsy or~~ inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy a few hrs
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Don't Know
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) N.A. Jamison, M. D.
(Coroner.)

8-28 1923 (Address) 1111 N Broadway St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Aug 30 1923
20 UNDERTAKER	ADDRESS
Jos Foerderer's Son	2178 E. Pratt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC-TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78692

CERTIFICATE OF DEATH.

31 D78692

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3414 Holmes Ave. ST., 15 WARD)

2-FULL NAME Annie B.McCurdy

(a) RESIDENCE NO. 3414 Holmes Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 10 mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene B.McCurdy

6 DATE OF BIRTH (month, day, and year) Oct.27 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	50	10	-----	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Louis J.Schaum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary C.Reather

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Eugene B.McCurdy

(Address) 3414 Holmes Ave.

Filed AUG 29 1923, 19 Robert F. Harrison, Registrar

Deputy Health Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug.27 1923

17 I HEREBY CERTIFY, That I attended deceased from Mar 13, 19 23, to Aug 27, 19 23, that I last saw her alive on Aug 27, 19 23, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular Heart Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) asthma

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J.E. Howard M. D.

8/29 1923 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Aug 30 1923
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Tubercular

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78693

CERTIFICATE OF DEATH.

90 D78693

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3425 Bateman Av ST. 15 WARD)

2-FULL NAME Andrew Knell Jr

(a) RESIDENCE NO. 3425 Bateman Av ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma A. Knell

6 DATE OF BIRTH (month, day, and year) Apr 12-1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	67	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Andrew Knell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant W. A. Knell

(Address) 4707 Forest Ave.

15 Filed AUG 30 1923 GS Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 25- 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 25th, 1923, to Aug 27th, 1923, that I last saw him alive on Aug 27th, 1923 and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis (Contributory)

(duration) 1 yrs. 2 mos ..... da.

CONTRIBUTORY (Secondary) Hypostatic Congestion

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. Wolsten, M. D.

, 19 (Address) 607 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cem	Aug 31 1923
20 UNDERTAKER Wm H Cook	ADDRESS 1003 N Calvert St

N. B.—WHITE PENCIL, WHITE CARDBOARD. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78694

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78694

44

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 Jackson ST. 24 WARD)

2-FULL NAME Ignatius Bunn

(a) RESIDENCE NO. 1516 Jackson ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 6 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Sallie V. Bunn

6 DATE OF BIRTH (month, day, and year) Feb 15 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	6	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Glass Blower.
(b) General nature of industry, business, or establishment in which employed (or employer) Glass Co
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Philip Bunn

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Lavia ?

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany.

14 Informant George Powley
(Address) 836 N. Paca St

15 Filed AUG 30 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1923

17 I HEREBY CERTIFY, That I attended deceased from March 15 1923, to Aug 28 1923,
that I last saw h alive on Aug 28 1923,
and that death occurred, on the date stated above, at 5.20 P m.
The CAUSE OF DEATH* was as follows:
Carcinoma of esophagus

(duration) yrs. 5 mos. 15 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....
Did an operation precede death? No Date of .....
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Samuel Erbaugh M.D.
(Address) 1412 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Cem (Hampden)	Aug 31 1923
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 N Bolton St

NOTE—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D78695 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78695

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 812 W. Mulberry St., 17 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Lottie Smith

(a) Residence No. 812 W. Mulberry St Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced (Write the word) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Unk 1874

7-AGE, 49 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) NR

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Balto.

PARENTS.

10-NAME OF FATHER, Wilson Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Harriet Colson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Va

14- (Informant) Mrs. Harriet Colson

(Address) 376 N. Carey St.

15- AUG 30 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 28-1923

17- I HEREBY CERTIFY, That I attended deceased from Aug 1, 19 23, to Aug 28, 19 23

that I last saw her alive on Aug 28, 19 24

and that death occurred, on the date stated above, at 8P m.

The CAUSE OF DEATH* was as follows:

Cardiac Lesion Valvular.

(Duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary) Ds. Pneumonia

(Duration) yrs. mos. 28 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? N.C. Date of

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) D.N. Fitzpatrick M. D.

Aug 27 19 23 (Address) 712 S. Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt. Auburn	Aug 31 19 23
20-UNDERTAKER. John H. Toadvine	ADDRESS 142 Eastern Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired,* 6 *yrs.*) For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

no other history.

D78696 HEALTH DEPARTMENT--CITY OF BALTIMORE 129 D78696

CERTIFICATE OF DEATH

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. Althea Ave. Gardenville St.; 96 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Weggel

(Residence in Baltimore: No. Althea Ave. Gardenville St.; 49 yrs. — mos. 10 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: M

4-COLOR OR RACE: W

5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Married

6-DATE OF BIRTH: Aug. (Month) 18, (Day) 1874 (Year)

7-AGE: 49 yrs. — mos. 10 ds. If LESS than 1 day, ... hrs. or — min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): 066

9-BIRTHPLACE (State or country): Balt

PARENTS

10-NAME OF FATHER: Geo E Weggel

11-BIRTHPLACE OF FATHER (State or country): Germany

12-MAIDEN NAME OF MOTHER: Mary C Hoechter

13-BIRTHPLACE OF MOTHER (State or country): Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sadie J. Weggel

(Address) Althea Ave

15.

Filed AUG 30 1923 GG. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH: Aug. (Month) 28, (Day) 1923 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 14, 1923, to Aug 27 1923

that I saw h alive on Aug 27, 1923

and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) ..... yrs. ..... mos. ..... ds

Contributory (SECONDARY)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo E Young M. D.

Aug 29, 1923 (Address) 1107 Lexington Bldg

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Balto. Cem. DATE OF BURIAL: Aug 31 1923

20-UNDERTAKER: Wm L Tuttle ADDRESS: 1728 Eutaw

N. B.-Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78697 D78697

CERTIFICATE OF DEATH.

Registered No. 57

1-PLACE OF DEATH

City of BALTIMORE: (No. 125 N Durham St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Sauer

(a) Residence No. 125 N Durham St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
F	W	Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Jacob Sauer

6-DATE OF BIRTH (month, day and year) August 23 1855

7-AGE,	If LESS than 1 day,
68 yrs. mos. 5 ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work House Wife 1

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Bath

PARENTS.

10-NAME OF FATHER, Andrew Bloch

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Ellnora Bloch

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Jacob Sauer

(Address) 125 N Durham

15- Filed 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Aug 28 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug 19 1923 to Aug 28 1923

that I last saw h[illegible] alive on Aug 28 1923

and that death occurred, on the date stated above, at 9:00 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Cellulitis

Neck (Duration) yrs. mos. 14 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? opened abscess Date of Neck

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Leo Feller M. D.

8/29, 1923 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Holy Redeemer	Aug 31, 1923
20-UNDERTAKER.	ADDRESS
Wendell Appleton	378 Penn

NOTE—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78698 44 D78698

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1615 N. Bradford St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Kilgus

(a) Residence No. ~~1615~~ 1615 N. Bradford St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, M

4-COLOR OR RACE, W

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Kilgus

6-DATE OF BIRTH (month, day and year) Oct 13 1864

7-AGE, 58 yrs. 10 mos. 15 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Brewer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer J.F. Wiessner

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, George Kilgus

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER, Dont Know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Catherine Kilgus

(Address) 1615 N. Bradford

15- Filed ..... 192 ..... Registrar.

AUG 30 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 28 1923

17- I HEREBY CERTIFY, That I attended deceased from June 1st 1923 to Aug 28 1923

that I last saw h— alive on Aug 27 1923

and that death occurred, on the date stated above, at 7:15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. Oney M. D.

, 19 (Address) 1603 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Aug 30, 1923
20-UNDERTAKER.	ADDRESS
Wendell Bissett & Son	31 S Howard

N. B.—WHITE PAPER, WRITE PLAINLY. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1005 Bks.

Ella Brown Furfield

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78699

CERTIFICATE OF DEATH.

74-991 D78699

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: No. 1729 Darley Ave ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Brown Furfield

a) RESIDENCE. No. 1729 Darley Ave ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Thomas Furfield

6 DATE OF BIRTH (month, day, and year) May 10, 1843.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER William Coarter

11 BIRTHPLACE OF FATHER (city or town) Bridlington, Eng
(State or country)

12 MAIDEN NAME OF MOTHER Ann Holmes

13 BIRTHPLACE OF MOTHER (city or town) England
(State or country)

14 Informant Mrs. Howard (daughter)
(Address) 1729 Darley Ave.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug 1 , 1923, to Aug 29 , 1923, that I last saw h alive on Aug 28 1923 and that death occurred, on the date stated above, at 2.05 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis. Hypertension
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? None Date of

Was there an autopsy? No

What test confirmed diagnosis? None save physical examination

(Signed) Isaac Bunde, M. D.

9/30, 1923. (Address) 1517 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL

Western Cem Sept 1 1923

20 UNDERTAKER ADDRESS

Woodrock. 502 E. Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 30 1923

COPY

Spec.—1-10-21—M&T—1500 Bks.

D78700

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D78700

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5107 Reisterstown Rd ST., 27 WARD)

2-FULL NAME Anna May Connelee

(a) RESIDENCE NO. 5107 Reisterstown Rd ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4/12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 1 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Wm E. Connelee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Blanche Wiggington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Blanche Connelee (Address) 5107 Reisterstown Rd

15 Filed AUG 30 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1923, to Aug 28, 1923, that I last saw h[illegible] alive on Aug 27, 1923, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Thro Colitis (duration) yrs. mos 28 ds.

CONTRIBUTORY (Secondary) Thro Colitis (duration) yrs. mos. 28 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W.S. Tibbett, M. D.

Aug 29/23 (Address) 2220 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Aug 30 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78701

CERTIFICATE OF DEATH.

74-001 ✓

D78701

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2925 E Madison ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Joseph Klima

(a) RESIDENCE No. 2925 E Madison ST., 7 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ✓ mos. ✓ ds. How long in U. S., if of foreign birth? ✓✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Klima

6 DATE OF BIRTH (month, day, and year) July 7th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
63		4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Bremen Germany

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Same as #10

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Mrs Sophia Manson

(Address) 2925 E Madison St

15 Filed ..... 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20, 1923, to Aug. 28, 1923, that I last saw h[illegible]ative on Aug 28, 1923 and that death occurred, on the date stated above, at 1230 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J Rysavek, M. D.

Aug 29 19 (Address) 801 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 9-1- 1923

20 UNDERTAKER Henry W Hentkes Sons Co

ADDRESS Orchard & Catherine

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78702

CERTIFICATE OF DEATH.

90 ✓ D78702

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 Dolphin ST.: 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Walter Scott

(a) RESIDENCE. NO. 520 Dolphin ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louisa Scott

6 DATE OF BIRTH (month, day, and year): Sept. 19, 1871

7 AGE: Years 51 Months 11 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): School

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Born and Raised

PARENTS

10 NAME OF FATHER: Daniel Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Born and Raised

12 MAIDEN NAME OF MOTHER: Annie Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Raised

14 Informant (Address): Mrs. Louise Scott 520 Dolphin St.

15 Filed AUG 30 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 8/27/ 1923.

17 I HEREBY CERTIFY, That I attended deceased from 8/18/ 1923. to 8/27/ 1923.

that I last saw him alive on 8/26/ 1923

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Cardiac Insufficiency

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. S. Hutchinson, M. D.

8/28/ 1923 (Address) 917 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: Aug 30 1923

20 UNDERTAKER: Samuel J. Kennedy ADDRESS: Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Influenza

Spec.—1-10-21—M&T—1500 Bks.

Dr. E. B. Freeman 412 Cathedral St

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1923 D78703

74-60 D78703

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 N Lexington ST. 20 WARD)

2-FULL NAME Charles F Bockel

(a) RESIDENCE NO. 1816 N Lexington ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE Louise Bockel

6 DATE OF BIRTH (month, day, and year) June 8th 1850

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
73	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Chas F Bockel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jno F Bockel (Address) Jones Falls & Govans

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 12 1923 to Aug 28 1923.

that I last saw him alive on Aug 28 1923.

and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
with Hemiplegia.

(duration) yrs. — mos. 16 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Elmer B Freeman M. D.

19 (Address) 412 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Aug 31 1923

20 UNDERTAKER F B Hesselbacher & Sons — ADDRESS Fremont Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78704

HEALTH DEPARTMENT—CITY OF BALTIMORE

48 D78704

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 9 WARD)

2-FULL NAME Alfred Harris

(a) RESIDENCE No. 1423 Aliceanna St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 131

(c) Name of employer

9 BIRTHPLACE (city or town) Oregon
(State or country)

PARENTS

10 NAME OF FATHER Thomas Harris

11 BIRTHPLACE OF FATHER (city or town) England
(State or country)

12 MAIDEN NAME OF MOTHER Mary Lubrin

13 BIRTHPLACE OF MOTHER (city or town) England
(State or country)

14 Informant Hospital Records -
(Address)

15 ..... 19 ..... Registrar

AUG 30 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/26 1923

17

I HEREBY CERTIFY, That I attended deceased from 3/12 .1923. to 8/26 .1923.

that I last saw him alive on 8/26 .1923

and that death occurred, on the date stated above, at 11:20 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of head & neck.

(duration) 2 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ?-

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No -

What test confirmed diagnosis? Laboratory Findings -

(Signed) Anthony V. Bueby M. D.

, 19 (Address) Municipal Hosp. -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND.	19
20 UNDERTAKER	ADDRESS
Commissioner Health.	AUG 30 1923

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78705

HEALTH DEPARTMENT—CITY OF BALTIMORE

164 D78705

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 N. Charles ST., 17 WARD)

2-FULL NAME John W. Boult

(a) RESIDENCE No. 1401 N. Charles ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaretta Boult

6 DATE OF BIRTH (month, day, and year): Nov 2 1839

7 AGE — Years: 83 — Months: 9 — Days: 27 — If LESS than 1 day, ...hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): 50

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Thos Blout

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Margaretta Blout
(Address) 1401 N. Charles st.

15 Filed AUG 30 1923, 19.....

Robert F. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 29 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 15 - 1923, to Aug 29th, 1923.

that I last saw h[illegible] alive on Aug 28, 1923,

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Senility (old age).

2 weeks
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas. H. Burkert, M. D.

Aug 29, 1923 (Address) 1100 W. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. — DATE OF BURIAL: 9/1 1923

20 UNDERTAKER: Chas. B. Wouerton — ADDRESS: 118 W. Mt. Royal Ave

A. B.—WRITE PLAINLY, WITH UNFADING INK—THE mation should be carefully supplied. AGE sho CAUSE OF DEATH in plain terms, so that it may TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D78706 HEALTH DEPARTMENT—CITY OF BALTIMORE D78706

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH Registered No.

City of BALTIMORE: (No. Mercy Hospital St., 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sarah Kyle

(a) Residence No. 1307 Linden Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, white

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6-DATE OF BIRTH (month, day and year) 1853

7-AGE. 70 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer). Housework

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Unknown?

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Hospital Records

(Address) Mercy Hospital

15- Filed AUG 30 1923 19 Robert F. Harrison Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 29-1923

17- I HEREBY CERTIFY, That I attended deceased from 8/28/23 19 to 8/29/23 19

that I last saw her alive on 8/27/23 19

and that death occurred, on the date stated above, at 11.20 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis.

(Duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. W. Holley M. D.

, 19 (Address) Mercy

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL. Aug 31 19 23

20-UNDERTAKER. Chas. E. Cramer & Son ADDRESS 118 W. Mt. Royal Ave

Burial Permit Issued

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78707

CERTIFICATE OF DEATH.

74-001 D78707

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital 6 WARD)

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sadie Peterson

(a) RESIDENCE NO. 204 N. ann ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1923

17

I HEREBY CERTIFY, That I attended deceased from March 4, 1922, to August 27 1923

that I last saw her alive on Aug. 27, 1923

and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Hypertension

Right Hemiplegia, Recurrent

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (Terminal) (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude B. Drace, M. D.

8-29 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	8/31 1923

20 UNDERTAKER ADDRESS

R. C. Gross 1405 McCulloh st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD—Every question must be answered. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic

Cor.—1-12-23—M&T—100 Bks.

D78708 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D78708

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1430 Ulrich Alley ST. 7 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rosa Bell Hemore

(a) RESIDENCE NO 1430 Ulrich Alley ST. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colrd

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years about 48 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER John H. Hemore

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Harriet Brown

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant William Martin
(Address) 411 So. Carrollton Ave

15 Filed ....., 192 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 28 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno B. Horton, M. D.
(Coroner)

Aug 28 1923 (Address) Curtis Bay Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Lem — DATE OF BURIAL 8/31 1923

20 UNDERTAKER R. C. Gross — ADDRESS 1405 McElderry st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC... TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Kunze)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78709 D78709

CERTIFICATE OF DEATH.

31

Registered No. 6189

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Ernest Kunze

(a) Residence No. 1218 W. Lexington St Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (~~Never married~~)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Separated from wife

6-DATE OF BIRTH (month, day and year) Oct 14, 1873

7-AGE, 50 yrs. 10 mos. 14 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Storeman

(b) General nature of industry, business, or establishment in which employed (or employer). 0

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Henry Kunze

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER Louisa Hultz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Hedwig Kunze

(Address) 1627 Barclay St.

15- Filed AUG 30 1923 Robt. P. Harrison Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 28 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug 15, 1923 to Aug 28 1923 that I last saw h.. alive on Aug 28 1923 and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 13 yrs. mos. ds

CONTRIBUTORY (Secondary) Perforated Gastric Ulcer

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? Not Known

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? X ray + Sputum

(Signed) L. A. Lally M. D

8/29, 1923 (Address) Municipal Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery DATE OF BURIAL, Aug. 31, 1923

20-UNDERTAKER, Mrs. Mrs. John H. Deufel Sr. ADDRESS 801 N. Fayette St.

AUG 30 1923

IMPORTANT. PHYSICIANS should state CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. WHITE FEMALES, MARRIED, should be stated in plain terms, so that it may be properly classified. NAMES of PARENTS should be given in full. Fill out all blanks. Use instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78710

CERTIFICATE OF DEATH.

49 D78710

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2321 W Lanvale ST. 16 WARD)

2-FULL NAME Elizabeth H Packham

(a) RESIDENCE NO. 2321 W Lanvale ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2 1850

7 AGE — Years: 72 — Months: 10 — Days: 27 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Detroit Mich.

PARENTS

10 NAME OF FATHER: Eldridge Packham

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Jane King

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: William H Packham

(Address) 2321 W Lanvale St.

15 Filed ..... 19.. Registrar

AUG 30 1923 Robert F. Morrison, Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1923

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1923, to Aug 28, 1923.

that I last saw her alive on Aug 28, 1923.

and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Urinary Bladder

(duration) yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Ex

(Signed) J. M. Lamprecht, M. D.

(Address) 826 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Aug 31 1923

20 UNDERTAKER: John O. Mitchell — ADDRESS: 320 W Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

78711 D78711 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78711

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hospital for Women of Md. ST.) 14 (WARD) 139 X

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Catherine Gamber

(a) RESIDENCE NO. Westminster, Md. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Reuben C. Gamber

6 DATE OF BIRTH (month, day, and year) June 16, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hampstead Carroll Co. Md.

PARENTS

10 NAME OF FATHER Milton Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll County Md.

12 MAIDEN NAME OF MOTHER Josephine Stoner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll County Md.

14 Informant Reuben C. Gamber (Address) Westminster, Md.

15 Filed AUG 31 1923 19 GL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 27, 1923, to Aug 30, 1923, that I last saw her alive on Aug. 30, 1923, and that death occurred, on the date stated above, at 9:10 P. m.

The CAUSE OF DEATH* was as follows:

Generalized Peritonitis following removal from abdomen of uterus with a large degenerated fibroma (infected)

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Fibroma uteri - degenerated & infected (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Westminster, Md.

Did an operation precede death? Yes Date of 8-28-23

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Ogle Warfield, Jr. M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster, Md.

DATE OF BURIAL Sept 2 1923

20 UNDERTAKER H B Bankard & Son

ADDRESS Westminster Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78712

CERTIFICATE OF DEATH.

D78712

REGISTERED NO. 73

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 W Saratoga ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Gray

(a) RESIDENCE NO. 1011 W. Saratoga ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 20, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress 041

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Caroline County Md.

PARENTS

10 NAME OF FATHER: John R Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: August Clyde

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Walter Henson

(Address) 011 W Saratoga

15 Filed AUG 31 19[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/28/ 1923

17 I HEREBY CERTIFY, That I attended deceased from July 26, 1923, to Aug 28, 1923, that I last saw her alive on Aug 27, 1923, and that death occurred, on the date stated above, at 1.40 A m.

The CAUSE OF DEATH* was as follows:

Acute Myelitis

(duration) yrs. 1 mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. H. Howell M. D.

8/31/ 1923 (Address) 1191 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MT Auburn Cem. DATE OF BURIAL: Aug 31 1923

20 UNDERTAKER: Samuel E Hemsley ADDRESS: 578 W Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH ITEM should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Accidental fall one year ago.

Spec.—1-10-21—M&T—1500 Blks.

D78713

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78713

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Colonial Hospital

CITY OF BALTIMORE: (No. 1122 N. Monroe ST., 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sara L. Etelson

(a) RESIDENCE NO. 1606 N. Monroe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. — mos. — ds. How long in U. S., if of foreign birth? 21 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	+ Months	+ Days	If LESS than 1 day, hrs. or min.
67				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant A. Etelson (Address) 1606 N. Monroe st

15 Filed AUG 31 1923 19 H. Lee Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 31 1923

17 I HEREBY CERTIFY, That I attended deceased from August 20, 1923, to August 31, 1923, that I last saw h alive on , 19 , and that death occurred, on the date stated above, at 12-05 a. m.

The CAUSE OF DEATH* was as follows:

Lobar-Pneumonia.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. P. Robinson M. D.

8/31 1923 (Address) Colonial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Ave

DATE OF BURIAL 8/31 1923

20 UNDERTAKER A. Levinson & Bro

ADDRESS 127 E. Balto st

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. DATA mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

Varlas

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78714 — 182 D78714

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Grace Yard (St.) 1776 (WARD)

2-FULL NAME John G Varlas

(a) RESIDENCE NO. 515 So. 14th St. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE o. Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	Ny	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 840
(c) Name of employer

9 BIRTHPLACE (city or town) Greece
(State or country)

PARENTS

10 NAME OF FATHER G. Varlas

11 BIRTHPLACE OF FATHER (city or town) Greece
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Greece
(State or country)

14 Informant Gus Biotakis
(Address) 612 So. 14th St

15 Filed AUG 31 1923 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest Aug 27 1923 thereon and from the evidence obtained by me (or at Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (Duration) yrs. mos. ds.

(Signed) Thos B Jackson M. D.
(Coroner)

Aug 31 1923 (Address) Curtis Bay Baltimore Md

*State the Disease Causing Death, or in deaths from violence state (1) Means and Nature of Injury and (2) whether Accidental Suicidal or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wood Lawn Cemetery — DATE OF BURIAL Aug 31 1923

20 UNDERTAKER George J. Ruth — ADDRESS 1735 Harford Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—II P. Co. 1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

078715 ✓ 078715

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2635 St Paul St. 17 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nina Shuttleworth

(a) RESIDENCE. No. 2635 St Paul ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House duties

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Va

PARENTS

10 NAME OF FATHER John Shuttleworth

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Louisa Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant (Address) Ella M. Shuttleworth Clarksburg W. Va

15 Filed AUG 31 1923 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1923

17

I HEREBY CERTIFY, That I attended deceased from August 16. 1923. to August 30. 1923.

that I last saw her alive on August 30. 1923.

and that death occurred, on the date stated above, at 9:25 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Carcinomatosis (duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis?

(Signed) C. H. Ingram M. D.

. 19 (Address) 2439 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Clarksburg W. Va	Aug 31 1923

20 UNDERTAKER ADDRESS

John Ottutelull 201 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should make mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78716

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-006 D78716

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Melvin S. Young St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carey and Baker st

(Residence in Baltimore: No. 2715 W North ave St.; yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Divorced

6-DATE OF BIRTH: May (Month) 26th (Day) 1896 (Year)

7-AGE: 27 yrs. 3 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Time Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): J Henry Miller

9-BIRTHPLACE, (State or Country): City

PARENTS:

10-NAME OF FATHER: Wm J. Young

11-BIRTHPLACE OF FATHER, (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Lucy Ellen Moore

13-BIRTHPLACE OF MOTHER, (State or Country): Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm J. Young

(Address) 2715 W. North Ave

15-

Filed AUG 31 1923 192.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 28, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushing injuries to body accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Caved in & ground

(Duration) yrs. mos. ds.

(Signed) J. J. Hennessy M. D. (Coroner.)

Aug 30, 1923 (Address) 2 E Madison ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Woodlawn

DATE OF BURIAL: Aug 31st 1923

20-UNDERTAKER: Wilbur D. Shriver

ADDRESS: 1018 Edmondson Ave

Spec.—1-10-21—M&T—1500 Blks.

1603-93 (")

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78717

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. " " " ST., 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sol Tieman.

(a) RESIDENCE NO. "A" St. Morrell Park, ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: August (father).

6 DATE OF BIRTH (month, day, and year): May ?-1923.

7 AGE: Years — Months 3 — Days — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child. pd

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: August

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Marguerite Chevalier.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: JOHNS HOPKINS HOSPITAL (Address) Records

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 28, 1923, to Aug 30, 1923.

that I last saw him alive on Aug 30, 1923.

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Diarrhoea (Not dysentary).

(duration) ..... yrs. ..... mos. 12+ ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Horton Casparis, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: Aug 31. 1923

20 UNDERTAKER: C. W. Dill — ADDRESS 3109 Frank. Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AUG 31 1923

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78718 — 123 — D78718

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 436 Rosedale Terace ST.: 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherena Gannon

(a) RESIDENCE. NO. 436 Rosedale Terace ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1 "1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer — —

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Dont Knew

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Kath Aloughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Wm Gannon
(Address) 436 Rosedale Terace

15 Filed AUG 31 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 29, 1923, to Aug 30, 1923, that I last saw her alive on Aug. 29, 1923, and that death occurred, on the date stated above, at 7.15 A.m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis
Cholecystitis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Perforation?

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Refused

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) C W Kolling, M. D.

8-31, 1923 (Address) 1120 N Paca

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Sept 3 1923

20 UNDERTAKER Mr - Miles & Son Print ADDRESS 1737 W Balto

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78719 HEALTH DEPARTMENT—CITY OF BALTIMORE D78719

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1522 Riggs Av St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Armistead Carter

(Residence in Baltimore: No. 1522 Riggs Av St.; yrs., 15 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

6-DATE OF BIRTH: about (Month) (Day) 1870 (Year)

7-AGE: 53 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Hod Carrier
(b) General nature of Industry, business, or establishment in which employed (or employer): General

9-BIRTHPLACE, (State or Country): Unknown

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER, (State or Country),

12-MAIDEN NAME OF MOTHER,

13-BIRTHPLACE OF MOTHER, (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. J. Stump

(Address) 1522 Riggs Av.

15-

Filed AUG 31 1923 Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 29 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

cerebral hemorrhage

(Duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(Duration) yrs. mos. ds.

(Signed) J. C. Hennessy M. D.
(Coroner.)

Aug. 30, 1923 (Address) 202 Edmondson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Auburn — DATE OF BURIAL, Aug 31 1923

20-UNDERTAKER, James H. Lewis — ADDRESS 303 Fremont St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78720

CERTIFICATE OF DEATH.

90 D78720

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 Stafford ST., 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred. K. Nicholas

(a) RESIDENCE NO. 509 Stafford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Julia Nicholas

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Pivots

(c) Name of employer Louis Burger

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Fred. K. Nicholas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliz. Hollis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Juanilla Rush

(Address) 1st Lanvale

15 Filed AUG 31 1923 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29th 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug. 28th 1923 to Aug 29th 1923 that I last saw h[illegible] alive on Aug 28th 1923 and that death occurred, on the date stated above, at 5.40 A.M.

The CAUSE OF DEATH* was as follows:

Acute dilitation of the heart

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) A. Lee Ellis, M. D.

, 19 (Address) 2 E Mont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Queenstown Md.	8-31 19 23
20 UNDERTAKER Daniel Easton	ADDRESS 916 Pa ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78721

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78721

CERTIFICATE OF DEATH.

49

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital - W. Fayette ST. 10 WARD)

2-FULL NAME George W. Devine

(a) RESIDENCE NO. 913 E. Eager St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? 73 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 24 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telegrapher 018

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER William Devine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Honor Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Rev Edw. Devine

(Address) 913 E. Eager St

15 Filed AUG 31 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1923

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1923, to Aug 29, 1923, that I last saw him alive on Aug 29, 1923, and that death occurred, on the date stated above, at 8:10 P m.

The CAUSE OF DEATH* was as follows:

Uremia of Period (Malignant)

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Edema of years

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas O'Donovan, M. D.

Aug 29, 1923 (Address) 5 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Sept 4-1923

20 UNDERTAKER H. C. Niedfeld — ADDRESS 914 Greenmount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78722

CERTIFICATE OF DEATH.

100-001 D78722

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital No ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James H. Cowman

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Municipal Hospital Records
(Address)

15 Filed , 19 G G. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 19 23

17

I HEREBY CERTIFY, That I attended deceased from Nov. 4, 19 17 to Aug. 29 19 23

that I last saw him alive on Aug. 29, 19 23

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted, if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude A. Hines, M. D.

8-30, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL 9/1 19 23

UNDERTAKER Chas. H. Evans & Son

ADDRESS 1118-20 W. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Everything contained in this information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78723

CERTIFICATE OF DEATH.

31 D78723

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 S. Ann Street ST., 7 WARD)

2-FULL NAME Leon . Urbanowski

(a) RESIDENCE NO. 303 S. Ann ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... information should be carefully supplied. AGE ... CAUSE OF DEATH in plain terms, so that it ... TION is very important. See instructions on ... NA-

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	16	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John. Urbanowski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Michalina Gutowski

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Mr John. Urbanowski
(Address) 303 S Ann Street

15 Filed ..., 19 ... G.G Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) aug 30 1923

17 I HEREBY CERTIFY, That I attended deceased from May, 1923, to Aug., 1923, that I last saw him alive on Aug 28, 1923, and that death occurred, on the date stated above, at 630 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) ...
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sent to sanatorium

(Signed) A.F. Reis, M. D.

aug 31 1923 (Address) 24 E Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cy

DATE OF BURIAL 3- 1923

20 UNDERTAKER John McWeber

ADDRESS 1803 Bank st

Spec.—1-10-21—M&T—1500 Blks.

D78724 HEALTH DEPARTMENT—CITY OF BALTIMORE D78724

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Fred White

(a) RESIDENCE NO. 4 N. Appleton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adelaide White

6 DATE OF BIRTH (month, day, and year) Unknown 1879.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44 yrs.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rigger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Frederick White

11 BIRTHPLACE OF FATHER (city or town) Ohio. (State or country)

12 MAIDEN NAME OF MOTHER Julia Hogan

13 BIRTHPLACE OF MOTHER (city or town) Ohio. (State or country)

14 Informant University Hosp Records (Address)

15 Filed AUG 31 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30, 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 30, 1920, to Aug 30, 1923, that I last saw him alive on Aug 30, 1923, and that death occurred, on the date stated above, at 11.20 P m.

The CAUSE OF DEATH* was as follows:

Bilateral Lobar Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 hrs

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical and Laboratory findings

(Signed) W Warren Walker, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL Sept 3rd 1923

20 UNDERTAKER Forget Cowan & Son

ADDRESS York & Clay

Per F J Cowan

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78725

CERTIFICATE OF DEATH.

129 D78725

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1505 W. Fayette St. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Abbie Moran,

(a) RESIDENCE NO. 1505 W. Fayette St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? 56 yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Moran,

6 DATE OF BIRTH (month, day, and year) Aug. 1. 1853.

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
70	—	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER John Delaney,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant William Moran,

(Address) 1505 W. Fayette St.

15 Filed AUG 31 1923 GL Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30. 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1. 1923. to Aug. 30. 1923, that I last saw he alive on Aug. 30. 1923, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. 6 mos — ds.

CONTRIBUTORY — (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Minute

(Signed) J. Theo. Horton, M.D.

8/31/23 19 (Address) 888 W. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL Sept 3 1923

20 UNDERTAKER John J. Fields 1205 W. Lombard — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN ... the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... of PATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78726

CERTIFICATE OF DEATH.

74-001 D78726

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 411 W. Saratoga ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorenz Kreyer

(a) RESIDENCE NO. 411 W. Saratoga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 79 yrs. 5 mos. 21 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Kreyer

6 DATE OF BIRTH (month, day, and year) Nov. 9—1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of Industry, business, or establishment in which employed (or employer) Offensmith

(c) Name of employer Balto.

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Lorenz Kreyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Jean C. Harbaugh

(Address) 411 W. Saratoga St.

15 Filed AUG 11 1923, 19 Robert P. Warfield, Registrar

Asst. Registrar Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30th 1923

17 I HEREBY CERTIFY, That I attended deceased from July 4th, 1923, to Aug 29, 1923, that I last saw h in alive on Aug 29, 1923, and that death occurred, on the date stated above, at 3 AM m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Atrophy

(duration) yrs. mos 2 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Frank Hyneman, M. D.

, 19 (Address) 522 N. Greene St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Sept 1st 1923

20 UNDERTAKER George L. Schwab ADDRESS 5101 Eudk. Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78727

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 48

D78727

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 W. Fayette ST., K WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Bolling

(a) RESIDENCE NO. 711 W. Fayette ST., WARD Greensboro N. Ca

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 3 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of James Bolling

6 DATE OF BIRTH (month, day, and year) Aug 17 - 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	66.	—	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house-wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

837

9 BIRTHPLACE (city or town) Rockingham Co., (State or country) North Carolina.

PARENTS

10 NAME OF FATHER Benjamin Orr

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Martha Daly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant James Bolling (Address) 711 W. Fayette St.

15 Filed AUG 31 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 30 1923.

17

I HEREBY CERTIFY, That I attended deceased from August 1st, 1923, to August 30th, 1923, that I last saw her alive on August 22, 1923, and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of face

(duration) — yrs. 8 mos — ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? North Carolina.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none.

(Signed) Chester Riland, M. D.

8-30, 1923 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greensboro N. C

DATE OF BURIAL Sept 1 1923

20 UNDERTAKER William Cook

ADDRESS 502 E Nora

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78728

CERTIFICATE OF DEATH.

129 D78728

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 N. Caroline ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Renehan

(a) RESIDENCE NO. 1023 N. Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. 11 mos. 20 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M. Louise Higgins

6 DATE OF BIRTH (month, day, and year) Sept. 10, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Assistant to Adjutant

(b) General nature of industry, business, or establishment in which employed (or employer) General State of Md.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Renehan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret A. Benzinger

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs. Louise H. Renehan
(Address) 1023 N. Caroline St.

15 Filed AUG 31 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 27, 1923, to Aug 30, 1923, that I last saw him alive on Aug 30, 1923 and that death occurred, on the date stated above, at 4.55 P m.

The CAUSE OF DEATH* was as follows:

Ac. Uremia

(duration) \ yrs. \ mos. 3 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) J. E. W. Talbot, M. D.

(Address) 1535 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	9/1 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78729

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78729

CERTIFICATE OF DEATH.

41

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 Hayward Avenue ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Lucas Mann

(a) RESIDENCE NO. 803 Hayward Avenue ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. -- mos. -- ds. How long in U. S., If of foreign birth? -- yrs. -- mos. -- ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances H. Fulmer

6 DATE OF BIRTH (month, day, and year) May 25, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .. min.
	48	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Photographer

(b) General nature of industry, business, or establishment in which employed (or employer) 056

(c) Name of employer

9 BIRTHPLACE (city or town) Johnstown
(State or country) New York

PARENTS

10 NAME OF FATHER Charles E. Mann

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New York ~~Do not know~~

12 MAIDEN NAME OF MOTHER Anna Lucas

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England. ~~Do not know~~

14 Informant Mrs. Frances H. Mann
(Address) 803 Hayward Avenue

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 30 1923

17 I HEREBY CERTIFY, That I attended deceased from August 25, 1923, to August 30, 1923, that I last saw him alive on August 30, 1923, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) ..... yrs. ..... mos 14 ds.

CONTRIBUTORY (Secondary) Infected teeth
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? All cases of blood examinations were made by personal reports by attending

(Signed) Geo. M. Gripp M. D.

Aug 31, 1923 (Address) 2435 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL 9/1 1923

20 UNDERTAKER Henry W. Mears & Son — ADDRESS 805 N. Calvert

Robert P. Harrison, Burial Permit Clerk.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D 78730

PLACE OF DEATH

City D78730

City 2042 Gough St. (No. 2042 Gough St.; Ward 7)

D78730

D. 78730

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

2 FULL NAME Ella A Vain

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6 DATE OF BIRTH: May 16th (Month) (Day) 1855 (Year)

7 AGE: 68 yrs. mos. ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Dr Wm H Farr.

11 BIRTHPLACE OF FATHER (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Eliza A Baker

13 BIRTHPLACE OF MOTHER (State or country): Baltimore Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James J Vain

(Address) 2042 Gough St.

15 Filed AUG 31 1923 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Aug (Month) 28 (Day) 1923 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 21, 1923 to Aug 28, 1923, that I last saw her alive on Aug 28, 1923, and that death occurred on the date stated above, at m.

The CAUSE OF DEATH * was as follows:

Dementia

(Duration) yrs mos ds.

Contributory (Secondary) Intersticial Nephritis

(Duration) 2 yrs mos ds.

(Signed) W H Thomas, M. D.

29 Aug, 1923 (Address) 301 Fellwood Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State. yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Baltimore Cemetery DATE OF BURIAL: Sept 1, 1923

20 UNDERTAKER: Robt F Turner & Son ADDRESS 1414 E Broadway

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1

FEE PAID

U.S.A.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78731

CERTIFICATE OF DEATH.

74-001 D78731

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2410 Francis ST., 13 WARD)

2-FULL NAME George W. Cumbrose

(a) RESIDENCE NO. 2410 Francis ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Cumbrose

6 DATE OF BIRTH (month, day, and year) March 20 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brick Layer
(b) General nature of industry, business, or establishment in which employed (or employer) Oil
(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS
10 NAME OF FATHER Joshua Cumbrose
11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) England
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) England

14 Informant Harry Cumbrose
(Address) 2410 Francis St

15 Filed AUG 31 1923, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1922, to Aug 29, 1923.
that I last saw him alive on Aug 28, 1923
and that death occurred, on the date stated above, at 7:45 a m.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis Arteriosclerosis
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of .....
Was there an autopsy? Yes
What test confirmed diagnosis? Physical Signs
(Signed) Edw Dalton, M. D.
8/31, 1923 (Address) 1355 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery
DATE OF BURIAL Aug 31 1923

20 UNDERTAKER Leo G. Cook
ADDRESS Northern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS' CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78732

CERTIFICATE OF DEATH.

40 D78732

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. May and Female Hospital ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary B. Weyrick

(a) RESIDENCE NO. 2918 W. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. 5 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Otto F. Weyrick

6 DATE OF BIRTH (month, day, and year) March 24th 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
	43	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER George M. Lohemann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Sidmayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Otto F. Weyrick (Address) 2918 W. Preston St.

15 Filed AUG 31 1923 . 19 Mary E. Harrison Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1923

17 I HEREBY CERTIFY, That I attended deceased from July 30 . 1923 to Aug 29 . 1923

that I last saw her alive on Aug 29 . 1923

and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 1 year yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of Aug 29-1923

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James H. Wildesen, M. D.

. 19 (Address) Md Gen'l Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL Sept 1st 1923

20 UNDERTAKER E. Schloman & Son

ADDRESS 1034 W. Lanvale St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS will note that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78733

CERTIFICATE OF DEATH.

(City) 74-901 D78733

1-PLACE OF DEATH Sunday Sanitarium No. REGISTERED NO. C

CITY OF BALTIMORE: (No. Fairmount Road ST.; 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Annie E. Patterson

(Residence in Baltimore: No. Sunday Sanitarium (City) St.; yrs. 6 mos. da.)

Brooklyn Md

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Widow

6-DATE OF BIRTH. ? (Month) (Day) 1854 (Year)

7-AGE. 69 yrs. mos. da.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER. Wm Sisk

11-BIRTHPLACE OF FATHER (State or Country). Md.

12-MAIDEN NAME OF MOTHER Lucetta Deaver

13-BIRTHPLACE OF MOTHER (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J. Sisk

(Address) Glyndon Md

15- Howard P. Morrison

Filed AUG 31 1923, 191 Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 31, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Dec 13 1922, to Aug 31 1923, that I saw h er alive on Aug 31 1923, and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. 1 mos. da.

CONTRIBUTORY (Secondary) Arteriosclerosis

(Duration) Unknown yrs. mos. da.

(Signed) Myron N. Cressman M. D.

Aug. 31, 1923 (Address) Relay Fairmount Rd.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death yrs. 6 mos. 14 da. In the State 6 yrs. mos. da.

Where was disease contracted, if not at place of death? Denton Md

Former or usual residence " "

19-PLACE OF BURIAL OR REMOVAL. Denton Md. DATE OF BURIAL. Sept 1, 1923

20-UNDERTAKER John Whitehead ADDRESS 1261 N. Fayette

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS are requested to write PLAINLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78734

CERTIFICATE OF DEATH.

129 D78734

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3968 Falls Road ST. 13 WARD)

2-FULL NAME Delphy J. Fuhrman

(a) RESIDENCE NO. 3968 E. Falls Road ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Georgie V. Fuhrman

6 DATE OF BIRTH (month, day, and year): Mar 9 1880

7 AGE: Years 43 Months 5 Days 25 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bookkeeper. 108

(b) General nature of industry, business, or establishment in which employed (or employer): American Tobacco Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co Md

PARENTS

10 NAME OF FATHER: William Fuhrman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co Md

12 MAIDEN NAME OF MOTHER: Mary J Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co Md

14 Informant: Mrs Georgie V. Fuhrman

(Address): 3968 Falls Road

15 Filed ..... 19 ..... Registrar

Robert P. Harrison

Deputy Chief Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 30 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1 1923, to Aug. 30 1923, that I last saw him alive on Aug. 30 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Parenchymatous Nephritis Pyelitis Edema of Brain (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) ..... Frank H. Hamblin, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge DATE OF BURIAL: Sept 1 23

20 UNDERTAKER: A. S. Mackall ADDRESS: 3539 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DG31923

D78735

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78735

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH — REGISTERED NO. C

CITY OF BALTIMORE (No. Municipal Hosp. St.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Andrew J. Fillmore

(Residence in Baltimore: No. 170 N. Potomac St. St.; yrs., Life mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Nov. (Month) 1 (Day), 1889 (Year)

7-AGE, 33 yrs. 9 mos. 29 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Machinist
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph G. Fillmore

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md.

12-MAIDEN NAME OF MOTHER Margaret Ruth

13-BIRTHPLACE OF MOTHER (State or Country), Baltimore Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margaret Fillmore

(Address) 170 N. Potomac St

15-

Filed SEP 1 1923 19.. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 30th (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

Duration 1 yr. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

Duration 2 yrs. mos. ds.

(Signed) Thos. J. Boxhorn M. D.
(Coroner)

Aug 31st, 1923 (Address) Curtis Bay Balto Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer Cem — DATE OF BURIAL, Sept. 1, 1923

20-UNDERTAKER Filby and Zeiler — ADDRESS 403 S. Wolfe St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

THIS IS A PERMANENT RECORD

Spec.—1-10-21 M&T 1500 Blks.

D78736

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D78736

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 612 S Decker Ave. WARD) 1

2-FULL NAME Fredrick C. Rohlfing, Jr.

(a) RESIDENCE NO. 612 S Decker Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24 1909

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
14	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Frederick C Rohlfing

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Minnie C Wolf

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Frederick C Rohlfing

(Address) 612 S. Decker Ave

15 Filed SEP 1 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30, 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1922, to Aug 30, 1923.

that I last saw him alive on Aug 30, 1923.

and that death occurred, on the date stated above, at 4:20 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X ray + bacteriology

(Signed) Joseph Pokadny, M. D.

, 19 (Address) 2124 Ashland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery — DATE OF BURIAL Sept 3 1923

20 UNDERTAKER John F Denny — ADDRESS 915 Light

Spec.—1-10-21—M&T—1500 Bks.

D78737

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78737

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728 Ashburton ST., 15 WARD)

2-FULL NAME Lowenia E Cooper

(a) RESIDENCE NO. 1728 Ashburton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Wht	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of A W. Cooper

6 DATE OF BIRTH (month, day, and year) Oct 30 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Lakeville
(State or country) Dorchester Co Md

PARENTS

10 NAME OF FATHER Wm Warfield

11 BIRTHPLACE OF FATHER (city or town) Lakeville
(State or country) Maryland

12 MAIDEN NAME OF MOTHER E. Cooper

13 BIRTHPLACE OF MOTHER (city or town) Lakeville
(State or country) Maryland

14 Informant Mrs. Martha A Schley
(Address) 1728 ashburton st

15 Filed ..., 19 ... Registrar

SEP 1 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1923

17 I HEREBY CERTIFY, That I attended deceased from July 15 1923, to Aug 31 1923, that I last saw h[illegible] alive on Aug 30 1923, and that death occurred, on the date stated above, at 3 45 a m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach with Metastasis of Liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Physicians Diagnosis

What test confirmed diagnosis?

(Signed) R. C. Mahaffey M. D.

Aug 31 1923 (Address) 1903 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood

DATE OF BURIAL Sep 3 1923

20 UNDERTAKER John F Denny

ADDRESS 915 L St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78738

CERTIFICATE OF DEATH.

160 D78738

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2124 Woodbury av ST.; 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Alma Bantes

(Residence in Baltimore: No. 2124 Woodbury av St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Aug (Month) 13 (Day), 1923 (Year)

7-AGE, yrs. mos. 18 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), 2124 Woodbury av

PARENTS.

10-NAME OF FATHER, George R Bantes

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER Margt E. Stephens

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) [illegible] Bantes

(Address) 2124 Woodbury Ave

15- SEP 1 - 1923 [illegible]

[illegible] 19[illegible] Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug (Month) 31 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 13 1923, to Aug 31 1923, that I saw her alive on Aug 30th 1923, and that death occurred, on the date stated above, at 12 PM.

The CAUSE OF DEATH* was as follows: Acute Catarrhal Nephritis

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Insanity

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Aug 31, 1923 (Address) 1816 Hunter st

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn

DATE OF BURIAL, Sept 1, 1923

20-UNDERTAKER Chenowith Son

ADDRESS Chestnut ave

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D78739 HEALTH DEPARTMENT—CITY OF BALTIMORE D78739

CERTIFICATE OF DEATH. X90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. WARD)

2-FULL NAME Mrs. Jessie Feller

(a) RESIDENCE NO. Annapolis, Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ H. C. Feller

6 DATE OF BIRTH (month, day, and year) About

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Edward Stuart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Jessie Abbot

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant (Address) Hospital records University Hospital

15 Filed ....., 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1923

17 I HEREBY CERTIFY, That I attended deceased from August 8, 1923, to August 31, 1923, that I last saw her alive on August 31, 1923 and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goitre

(duration) 9 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Annapolis, Md.

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis?

(Signed) J. A. T. Hundley, Jr., M. D.

8/31, 1923 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Portsmouth Va

DATE OF BURIAL S. 01 1923

20 UNDERTAKER William Cook 502 E Main

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78740

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78740

100-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat St. 24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia Keller

(a) RESIDENCE. No. 221 Knox Alley St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of No.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Fichtenau
(State or country) Germany

PARENTS

10 NAME OF FATHER John Fred. Keller

11 BIRTHPLACE OF FATHER (city or town) Bakeren
(State or country)

12 MAIDEN NAME OF MOTHER Sophie Eleanor Edel

13 BIRTHPLACE OF MOTHER (city or town) Fichtenau
(State or country) Province Hanover

14 Informant Mt Hope Retreat
(Address)

15 Filed SEPT 1 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 1923

17 I HEREBY CERTIFY, That I attended deceased from July 25, 1923, to Aug 29, 1923, that I last saw her alive on Aug 29, 1923, and that death occurred, on the date stated above, at 8.45 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Senile Mania.

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Mt Hope Retreat

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Hill, M. D.

(Address) Wyliesville - Reisterstown Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK CEMETERY	SEPT 1 1923

20 UNDERTAKER ROBERT BROOKS & SON ADDRESS COR CALHOUN HOLLINS ST

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78741

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

(Toy) 31 X

D78741

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1914 Brunt ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alexander Toy

(a) RESIDENCE No. 1914 Brunt St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Josephine Toy

6 DATE OF BIRTH (month, day, and year): June 3rd

7 AGE: Years 36 Months 2 Days 28 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Calvert Co Md

PARENTS

10 NAME OF FATHER: Kelley Toy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Died Young

12 MAIDEN NAME OF MOTHER: Harriet White

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Josephine Toy (Address) 1914 Brunt St

15 Filed: FEB 1 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug. 31, 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1923, to ....., 19..., that I last saw him alive on Aug. 30, 1923, and that death occurred, on the date stated above, at 12:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute indigestion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No physical examinati

What test confirmed diagnosis? only symptomatic and

(Signed) L. F. Flemmell M. D.

8/31/1923 (Address) 2226 Madison Ave.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (Use reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holland St. DATE OF BURIAL: Aug 19 23

20 UNDERTAKER: Emanuel Wesley ADDRESS: Fulton Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.P.S.—400 Bks.

D78742

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78742

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Municipal T.B. Hosp. St., 5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Brown

(a) Residence No. 301 N. Eden St St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	Colored	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) unknown. 1900

7-AGE.	If LESS than 1 day,
23 yrs. mos. ds.	hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Albert Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Smith

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Hospital Records

(Address)

15- Filed SEP 1 - 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 29-1923

17- I HEREBY CERTIFY, That I attended deceased from Aug 6, 1923, to Aug 29, 1923

that I last saw h. alive on Aug 29, 1923

and that death occurred, on the date stated above, at 5.15 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray - Sputum

(Signed) L. G. Lahey, M. D.

, 19 (Address) Municipal T.B. Hosp.

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Ashbury Cemetery	Sept. 1, 1923
20-UNDERTAKER.	ADDRESS
Milton Davis	315 N Eden St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78743

CERTIFICATE OF DEATH.

44 D78743

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5002 Wesley ST.; 28 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lena Cassell

(Residence in Baltimore: No. 5002 Wesley ave St.; ....yrs., ...mos. ....ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: white

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.): Married

6-DATE OF BIRTH, Dec 15 (Month) (Day), 1866 (Year)

7-AGE, 56 yrs. 8 mos. 15 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): Home

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Frederick Georges

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Amelia Wolf

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellsworth Cassell

(Address) 5002 Wesley ave

15-

Filed....., 191.....

SEP 1 - 1923 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 30 (Month) (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 1 1923, to Aug 30 1923, that I saw h[illegible] alive on Aug 30 1923, and that death occurred, on the date stated above, at 4:40 a.m.

The CAUSE OF DEATH* was as follows:

Cancerous Tumors
Liver & Stomach

(Duration) ....yrs. 8 mos. ....ds.

CONTRIBUTORY (Secondary) Intussusception

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas R Davis M. D.

Aug 31 1923 (Address) 2100 Broadway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, London Park — DATE OF BURIAL, Sept 1 1923

20-UNDERTAKER Geo Herbert Son 2503 ADDRESS Edmondson ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78744

CERTIFICATE OF DEATH.

90 D78744

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1718 Linden Ave ST., W WARD)

2-FULL NAME Frances Boucher

(a) RESIDENCE NO. 1718 Linden Ave ST., 14 WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Boucher

6 DATE OF BIRTH (month, day, and year) Feb 15, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	80	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER James Giles

11 BIRTHPLACE OF FATHER (city or town) London (State or country) England

12 MAIDEN NAME OF MOTHER Eliz McMullen

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant Estelle Bowdley

(Address) Delaware Road Catonsville

15 Filed SEP 1 1923, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-31 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1923, to Aug. 31, 1923, that I last saw her alive on Aug. 30th, 1923, and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Entero-Colitis

(duration) ..... yrs. ..... mos 16 ds.

CONTRIBUTORY (Secondary) Myocard-Ty-

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm. T. Lockwood M. D.

, 19 (Address) 8 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 9-3 1923

20 UNDERTAKER Heuisler & Jenkins Bros Co

ADDRESS McCulloh and Orchard

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

D78745 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78745

31

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1430 Gough St ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sophie Lendios

(Residence in Baltimore: No. 1430 Gough St St.; 30 yrs., mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, ... (Month) ..... (Day) 1859 (Year)

7-AGE, 64 yrs. ..... mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): ?

9-BIRTHPLACE, (State or Country), Poland

PARENTS.

10-NAME OF FATHER, J. Goreske

11-BIRTHPLACE OF FATHER (State or Country), Poland

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. Lendios

(Address) 1430 Gough St

15- Filed SEP 1 - 1923 19..... Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. (Month) 31 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 27 1923, to Aug 31 1923, that I saw h[er] alive on Aug. 30 1923, and that death occurred, on the date stated above, at 7 40 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatic heart disease

? (Duration) yrs. mos. ds.

(Signed) Fred A. Rau M. D.

9/1/23 1923 (Address) 245 B'dway

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Rosary

DATE OF BURIAL, Sept. 3, 1923

20-UNDERTAKER J. Fiallkowski

ADDRESS 419 Bond

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78746

CERTIFICATE OF DEATH.

160 D78746

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Eutaw ST. 14 WARD)

2-FULL NAME Russell Mason

(a) RESIDENCE. No. 604 Eutaw ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr. 1st 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Albert Rose

11 BIRTHPLACE OF FATHER (city or town) Madjoe
(State or country) Portugal

12 MAIDEN NAME OF MOTHER Rebecca Mason

13 BIRTHPLACE OF MOTHER (city or town) Rockaway County
(State or country) Va.

14 Informant Mrs. Carrie McCauley
(Address) 1604 Eutaw St.

15 Filed SEP 1 - 1923 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 20th, 19 23, to Aug 30th, 19 23, that I last saw h[illegible] alive on Aug. 30th, 19 23, and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Marasmus.

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Wm. L. McBell, M. D.

, 19 (Address) 132 N. Dithridge St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 9/1 19 23

20 UNDERTAKER Jas. T. Dennis

ADDRESS 1313 Fremont

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78747

CERTIFICATE OF DEATH.

101-001 D78747

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Woodyear ST., 16 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Jackson

(a) RESIDENCE No. 1125 Woodyear ST., ... WARD
(Usual place of abode)
Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE Colored | 5 Single, Married, Widowed, or Divorced, (write the word) Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Jackson

6 DATE OF BIRTH (month, day, and year) Aug-13-1859

7 AGE — Years 64 | Months — | Days 16 | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Horseware. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Deborah Jackson

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Osborne Jackson
(Address) 1125 Woodyear

15 Filed SEP 1 - 1923 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 29 1923

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1923, to Aug 29, 1923.
that I last saw him alive on Aug 28, 1923.
and that death occurred, on the date stated above, at 7.10 A, m.
The CAUSE OF DEATH* was as follows:
Pneumonia Lobar

(duration) yrs. 1 mos 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. H. Gordon, M. D.

(Address) 712 S. Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 9/1 1923

20 UNDERTAKER Saml H Kemsley

ADDRESS Bolton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78748

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002 D78748

CERTIFICATE OF DEATH

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 4 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Dean

(a) RESIDENCE No. 312 Otterbein ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Truck Driver

(b) General nature of industry, business, or establishment in which employed (or employer) 123

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Dean

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records (Address)

15 Filed SEP 1 - 1923 19 GG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-31 1923

17 I HEREBY CERTIFY, That I attended deceased from 8-14, 1923, to 8-31, 1923, that I last saw him alive on 8-31, 1923, and that death occurred, on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows: Intestinal obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic appendicitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8-17-23

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) R. H. Taylor, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cheltenham Ken Co	9/3-23 19
UNDERTAKER	ADDRESS
Jones & Jonson	12 & 14 N Gay St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78749

CERTIFICATE OF DEATH.

71-002

D78749

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1 1 1 ST., 1 WARD)

2-FULL NAME Pearl Collins

(a) RESIDENCE NO. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 24 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant JOHNS HOPKINS HOSPITAL (Address) Records

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 26 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 26, 1923, to Aug 26, 1923, that I last saw h.. alive on Aug 26, 1923, and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis Streptococcus

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) T. R. Hannon M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

1923 Aug 26

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec– 12-23-21– S.B.R.S.—400 Bks.

D78750 HEALTH DEPARTMENT—CITY OF BALTIMORE.

31 D78750

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No. 5993

City of BALTIMORE: (No. Municipal Tubercular Hospital 25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Simmons

(a) Residence No. 1 Marshall St. St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, or Divorced, (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6-DATE OF BIRTH (month, day and year)

7-AGE. 70 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

015

9-BIRTHPLACE (city or town) (State or Country). Maryland

PARENTS

10-NAME OF FATHER. Levin Simmons

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Elizabeth Frazier

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Md.

14- (Informant) Samuel Simmons

(Address) 1 Marshall St.

15- Filed 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 8-29-23

17- I HEREBY CERTIFY, That I attended deceased from Jan. 2 1923 to Aug 29 1923

that I last saw him alive on Aug 29 1923

and that death occurred, on the date stated above, at 12.10 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Sputum & X-ray

(Signed) L. G. Ladley M. D.

, 19 (Address) Municipal Tub. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. 19

20-UNDERTAKER. ADDRESS

STATE OF MARYLAND

N. B.—WRITE PLAINLY, WITH UNFADING INK. NAME should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

26

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78751

CERTIFICATE OF DEATH.

X 188-003 D78751

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 25 WARD)

2-FULL NAME Geo Clews -

(a) RESIDENCE NO. Savage md ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
9	9			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer —

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Rev M. Clews

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) " "
(State or country)

14 Informant Rev M Clews
(Address) Savage Md

15 Filed SEP 2 - 1923, 192 Robert E Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-31 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia d

(duration) ... yrs. ... mos. 3 ds.

CONTRIBUTORY (Secondary) Compound fracture L. Leg

(duration) ... yrs ... mos. 3 ds.

(Signed) W B Jones, M. D.
(Coroner.)

8-31, 1923 (Address) 1 W Laurel Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death .... yrs., ... mos., ... ds. In the State .... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, ~~CREMATION~~ OR REMOVAL Laurel Md

DATE OF BURIAL Sept 3rd 1923

20 UNDERTAKER E & B Harle

ADDRESS 115 E. Hyde St Balto Md

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D78752

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 100-001

D78752
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 3 WARD)

2-FULL NAME Frank Kott

(a) RESIDENCE NO. 1614 Eastern Ave St., WARD
(Usual place of abode)
Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE s CAUSE OF DEATH in plain terms, so that it TION is very important. See instructions on

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed ..... 19 .....
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 27 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 3, 1923, to Aug 27, 1923 that I last saw him alive on Aug. 27, 1923, and that death occurred, on the date stated above, at 9:30 p.m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Senile Dementia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude B. Heran, M. D.

8-29, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Forest Cemetery	Sept 1 1923
20 UNDERTAKER	ADDRESS
Jno C. Keiler	2334 Eastern Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78753

CERTIFICATE OF DEATH.

100-001 D78753

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Municipal Hospital St., 96 WARD)

2-FULL NAME Annie Haughton

(a) RESIDENCE NO. 3603 E. Pratt ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed ....., 19 .....

Robert P. Harrison,
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 13, 1923 to Aug 31, 1923

that I last saw h[illegible]alive on Aug. 31, 1923

and that death occurred, on the date stated above, at 12[illegible] m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (Terminal)

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude B. Drake, M. D.

8/31, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	Sept 5 1923
20 UNDERTAKER	ADDRESS
Wm C. Muller	233 Hoffman

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. 78744

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78754 CERTIFICATE OF DEATH. 154-003 D78754

1-PLACE OF DEATH Maryland General Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Saunders.

(a) RESIDENCE NO. 1316 W. Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 0 mos. 0 ds. 7 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE white | 5 Single, Married, Widowed, or Divorced, (write the word) Single Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 24, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	0	0	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Patterson Saunders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Winston-Salem North Carolina.

12 MAIDEN NAME OF MOTHER Mary Hubbard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Petersburg Virginia

14 Informant Hospital records
(Address)

15 Filed SEP 2 1923, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1923, to Aug 31, 1923, that I last saw her alive on Aug 31, 1923, and that death occurred, on the date stated above, at 8:15 P.m.

The CAUSE OF DEATH* was as follows:

Inanition

(duration) 0 yrs. 0 mos 7 ds.

CONTRIBUTORY (Secondary) Congenital Deformities

(duration) ... yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) W. H. Coleman M. D.

, 19 (Address) Md. Gen'l Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem | DATE OF BURIAL Sept 1 1923

20 UNDERTAKER J Mitchell | ADDRESS 1201 Fayette St.

N. B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. EVERY mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OC TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

078755

HEALTH DEPARTMENT—CITY OF BALTIMORE

078755

CERTIFICATE OF DEATH. 58-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Canterbury Road & 39th ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clara Wells Sandman

(a) RESIDENCE No. Canterbury Road & 39th. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August G. Sandman

6 DATE OF BIRTH (month, day, and year) ----------

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William H. Ritchie

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Ray

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant August G. Sandman
(Address) Canterbury Road & 39th. St

15 Filed SEP 2 1923, 19 Robert P. Garrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from June 10th, 1923, to Sept. 1st, 1923, that I last saw h w alive on Sept. 1st, 1923, and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia
unknown
(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood examination

(Signed) George E. Cross, M. D.

, 19 (Address) 2409 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	9/3, 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE s CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See Instructions on back of certificates.

D78756

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78756

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 220 aisquith St 5 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Klein

(Residence in Baltimore: No. 220 aisquith Street St., 20 yrs., mos., ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
M	White	M

6-DATE OF BIRTH. March 28 1891
(Month) (Day) (Year)

7-AGE. 32 yrs. 5 mos. 3 ds. If LESS than 1 day, ...hrs. or....min.*

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Tailor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Russia

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER, (State or Country). Russia

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jack Lewis

(Address) 1439 E Baltimore St

15-

Filed SEP 2 - 1923 192.... Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug 31 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

One week (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
(Coroner.)

Sept 1 192 3 (Address) 1439 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Hebrew Herring Run	9/2 192 3

20-UNDERTAKER	ADDRESS
Jack Lewis	1439 E Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78757

CERTIFICATE OF DEATH.

84 D78757

1-PLACE OF DEATH Church Home and Inf.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 136 N. Broadway ST., 12 WARD)

2-FULL NAME Mrs. Bessye Washer Krug

(a) RESIDENCE No. 220 W. 27th ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced
HUSBAND of (or) WIFE of Emanuel Nasser Krug

6 DATE OF BIRTH (month, day, and year) March 1897

7 AGE: Years 26 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) 231
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel Rosen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sophie Sholowitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis
(Address) 1439 Eutaw St

15 Filed ....., 19.. Robert P. Harrison, Registrar

SEP 7 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1923, to Aug 31, 1923, that I last saw h alive on Aug 31, 1923, and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) ..... yrs. 9 mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug 31 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Richard S Coblentz, M. D.

, 19 (Address) Church Home and Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Baedale — DATE OF BURIAL 9/7 1923

20 UNDERTAKER Jack Levis 1439 Eutaw St — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non-Malignant

Spec—12-23-21—E.B.R.S.—400 Bks.

D78758

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-002 D78758

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2502 Linden ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simma Weinberg

(a) Residence No. 2502 Linden ave St., ... Ward.....
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? 35 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year)

7-AGE. 92 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Russia

PARENTS.

10-NAME OF FATHER, Sam Shaw

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Mrs Anna Rosenberg

(Address) 2502 Linden ave

15-

Filed ..... Robert P. Harrison. Registrar.

SEP 2 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 8/31/23

17- I HEREBY CERTIFY, That I attended deceased from Aug 1 1923 to Aug 31 1923

that I last saw h.. alive on Aug 31 1923

and that death occurred, on the date stated above, at 2 15 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J. Frederick Leitz M. D.

8/31, 1923 (Address) 7040 Eutaw St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Balto Hebrew Cemet DATE OF BURIAL, 9/2 1923

20-UNDERTAKER. Sol Levinson Bro ADDRESS 1127 E Balto st

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78759

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 ✓ D78759

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Lansing Ave. WARD) 8

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis X Doerfler

(a) RESIDENCE No. 1715 Lansing Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): March 16/23

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Peter J. Doerfler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mary A. Dickl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt.

14 Informant: Peter J. Doerfler

(Address): 1411 Eastlake Ave

15 Filed SEP 6 1923, 19

Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 9th 23, 19.., to Sept 4th 23, 19..,

that I last saw him alive on Sept 4th, 19 23,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cystic Intestinal Stenosis

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

(Address) 1101 E. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sep 3 1923
20 UNDERTAKER	ADDRESS
Frank A. Fink	910 E Lanvale

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S should be stated EXACTLY. AGE should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78760

CERTIFICATE OF DEATH.

X 90 ✓ D78760

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 N. Carrollton Ave ST., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Elizabeth Hall

(a) RESIDENCE NO. 1109 N. Carrollton ave ST., WARD West River Md.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Widowed

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Samuel Hall

6 DATE OF BIRTH (month, day, and year) Mar 24 1872

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md

PARENTS

10 NAME OF FATHER John Bordley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md

12 MAIDEN NAME OF MOTHER Annie Lane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md

14 Informant Annie Amos

(Address) 1320 McCulloh

15 Filed SEP 2 1923, 19 Robert F. Harrison, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1923, to Aug 31, 1923, that I last saw him alive on Aug 30, 1923, and that death occurred, on the date stated above, at 5.40 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chr. Valvular Heart disease

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Annapolis Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Paul Brown M. D.

8/31, 1923 (Address) 1837 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. A. Brien A.A.B.

DATE OF BURIAL: 9/3 1923

20 UNDERTAKER: Robert E. Williams

ADDRESS: 515 McCulloh St

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIANS should state mation should be carefully supplied. AGE, should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78761

HEALTH DEPARTMENT—CITY OF BALTIMORE

16-002

D78761

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. So Balto Gen Hosp. WARD) 25

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Szczepkowski

(a) RESIDENCE NO. East Brooklyn Hospt Baltimore WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Ana Szczepkowski.

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Canning Factory

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant M. F. Sadowski 705 S. Ann St. (Address) for Mrs. Szczepkowski East Brooklyn Hospital

15 Filed ..... 19 ..... Registrar

Assistant Farmie Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8/31 1923

17

I HEREBY CERTIFY, That I attended deceased from 8/24, 1923, to 8/31, 1923, that I last saw him alive on 31st, 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dysentery

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) H. C. Warfield, M. D.

8-31-1923 (Address) East Balto Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross. A. A. Co. Md	Sept 3rd 1923
20 UNDERTAKER	**ADDRESS**
M. F. Sadowski	705 S. Ann

N. B.—WHITE PRINTED, WITH CHARCOAL INK. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Bacillary

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78762 44 D78762

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Christs Institution Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 704 Ensor ST., (WARD)

2-FULL NAME Stanislawa ~~Estella~~ Cudzik

(a) RESIDENCE NO. 512 So Castle ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~: Frank Cudzik.

6 DATE OF BIRTH (month, day, and year): July 23/86.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Walenty Michalick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Witonia Adamski

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant (Address): 512 S. Castle St.

15 Filed SEP 2 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1923. to September 1, 1923. that I last saw her alive on September 1, 1923 and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

apoplexy

Carcinoma of stomach (duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Carcinoma of stomach (duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? 512 castle St Balto Md.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. Wisniewski, M. D.

(Address) 704 Ensor St 9-1, 1923

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus. DATE OF BURIAL: Sep. 4th 1923

20 UNDERTAKER: W. F. Sodowski. ADDRESS: 705 S. Am

NOTE—WRITE PLAINLY WITH UNFADING INK. PHYSICIANS should be careful, when ordering CERTIFICATES, that the information should be carefully supplied. AGE, should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78763 D78763

CERTIFICATE OF DEATH.

31

Registered No. 6141

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal T.B. Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Leggin (or Love)

(a) Residence No. 951 Druid Ave St. Balto Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	Colored	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Love

6-DATE OF BIRTH (month, day and year)

7-AGE.	If LESS than 1 day,
20 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) 170

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Pennsylvania

PARENTS.

10-NAME OF FATHER, Alexander Long

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Virginia

12-MAIDEN NAME OF MOTHER, Eleanor Watkins

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Pennsylvania

14- (Informant) Mrs Catherine Love Talin Leggin

(Address) 951 Druid Ave City

15- Robert P. Harrison

Filed 192 Registrar.

Burial Permit Clerk.

Note.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Aug 30, 1923

17- I HEREBY CERTIFY, That I attended deceased from June 27 1923 to Aug 30 1923

that I last saw her alive on Aug 30 1923

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. mos. 4 ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X ray + Sputum

(Signed) L. A. Talley M. D

, 19 (Address) Municipal TB Hospital

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Wilkesbarre Pa	Sept 3 1923
20-UNDERTAKER.	ADDRESS
John H. Toadvine	Wilkesbarre Pa

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSES OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78764

CERTIFICATE OF DEATH.

X 60-001 D78764

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Ellis.

(a) RESIDENCE NO. Saxis Virginia ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1907.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	Sixteen	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER John. Ellis.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Lucy Litton.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant University Hospital Records (Address)

15 Filed ..... 19 ..... Registrar

Robert T. Garrison, Burial Permit Clerk.

SEP 2 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2, 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug 7- 1923, to Sept 2. 1923, that I last saw her alive on Sept 2 1923, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Thyro-toxicosis

(duration) yrs. 6. mos da.

CONTRIBUTORY (Secondary) Myocardial Insufficiency.

(duration) yrs. mos. 1. da.

18 Where was disease contracted if not at place of death? Saxis Virginia

Did an operation precede death? Yes Date of 8/11/23.

Was there an autopsy? None.

What test confirmed diagnosis? Clinical Tests.

(Signed) R J Pemberton, M. D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Crisfield Md.

DATE OF BURIAL: Sept. 4 1923

20 UNDERTAKER: L. Heimann

ADDRESS: 52 S. Edwy.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Exspectatum Exitum

Spec.—1-10-21—M&T—1500 Bks.

165075 D78765

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D78765

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. " " " ST., 76 WARD)

2-FULL NAME Ida Johnson.

(a) RESIDENCE NO. 4026 Hoffman St. ST. City. WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: Colored
5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Cornelius Johnson (Husband)

6 DATE OF BIRTH (month, day, and year) 1883.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	2	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H. W.
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) .....
(State or country) Md.

PARENTS
10 NAME OF FATHER Frink Powell.
11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Va
12 MAIDEN NAME OF MOTHER Fanny Mutt.
13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Va

14 Informant JOHNS HOPKINS HOSPITAL.
(Address) Wards

15 Filed ..... 19 ..... Registrar

SEP 2 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1923. to Aug 31 .1923.
that I last saw her alive on Aug 31, .1923.
and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:
Myocardial insufficiency

(duration) ..... yrs. 2 mos ..... ds.

CONTRIBUTORY (Secondary) None
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Thos Owen ..... M. D.

Sept 1, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — DATE OF BURIAL: Sept 20, 23

20 UNDERTAKER James N. Deeds — ADDRESS Frederick

NOTE—PHYSICIANS, write plainly. AGE should be stated EXACTLY. PHYSICIANS should be careful to state mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78766

CERTIFICATE OF DEATH.

129 ✓ D78766

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1125 Light St., 24 WARD)

2-FULL NAME Bernard Bahlman

(a) RESIDENCE No. 1125 Light St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): W.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Bahlman

6 DATE OF BIRTH (month, day, and year): April 14, 1875

7 AGE: Years 48 | Months 4 | Days 17 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

074

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Bahlman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christina Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frieda Elliott

(Address) 1125 Light St.

15 Filed ..... 19 ..... Registrar

Robert J. Harrison, Burial Permit Clerk

P2 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 31 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 15, 1923, to Aug 31, 1923, that I last saw him alive on Aug 31, 1923, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No Medical

What test confirmed diagnosis? .....

(Signed) Bernard Bahlman, M. D.

(Address) 1125 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Schwartz Cem

DATE OF BURIAL: Sept. 2, 1923

20 UNDERTAKER: Margaret J. Flynn

ADDRESS 1422 Light St.

A CERTIFICATE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78767

CERTIFICATE OF DEATH.

120 ✓

D78767

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 733 Mc Henry ST. 21 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Riley

(a) RESIDENCE. NO. 733 Mc Henry ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edw. M. Riley

6 DATE OF BIRTH (month, day, and year) Feb. 17, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER Patrick Nedley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Florida

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Thelma C. Storm (Address) 410 N. Monroe St

15 Filed ..... 19 ..... Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 30 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 12, 1923, to Aug 30, 1923, that I last saw her alive on Aug 29, 1923, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Acute Yellow Atrophy of Liver

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Dilcrett, M. D.

, 19 (Address) 624 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 3, 1923

20 UNDERTAKER Margaret G. Flynn (ADDRESS) 1121 Light St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

(Fagins)

D78768 HEALTH DEPARTMENT—CITY OF BALTIMORE D-78768

CERTIFICATE OF DEATH. 159-00289820

1-PLACE OF DEATH

City of BALTIMORE: (No. 109-W. 20 St., 12 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lee Oscar Fagins

(Residence in Baltimore: No. 109 W 20th St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
female	colored	Single

6-DATE OF BIRTH. Sept 1st 1923 (Month) (Day) (Year)

7-AGE. 1/2 Hour — If LESS than 1 day, ...hrs. or ....min.

yrs. mos. ds.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Balto md

PARENTS

10-NAME OF FATHER. Julius Fagins

11-BIRTHPLACE OF FATHER. (State or Country). N C.

12-MAIDEN NAME OF MOTHER. Julia Veney

13-BIRTHPLACE OF MOTHER. (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Julius Fagins

(Address) 109 W 20th St

15-

Filed SEP 2-1923 19.. Robert P. Harrison, Registrar.

Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 1 (Month) (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said decased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart disease

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) John J. Monroe M. D. (Coroner)

Sept 2 1923 (Address) 3632 Reisterstown Rd

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	Sept 3 1923

20-UNDERTAKER. Joseph A. Farrell ADDRESS 2519 Division

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

165084. D78769

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1132 D78769

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 915 WARD)

2-FULL NAME Rebecca Waller

(a) RESIDENCE No. 614 Gold St. City ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. Since ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced ~~HUSBAND~~ (or) ~~WIFE~~ of Barbara Mother.

6 DATE OF BIRTH (month, day, and year) April-23

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
———	4	27,	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer): ———

(c) Name of employer: ———

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Tom Tossin.

11 BIRTHPLACE OF FATHER (city or town) (State or country): ———

12 MAIDEN NAME OF MOTHER Barbara Waller.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ———

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records.

15 Filed SEP 2 1923, 19.. Robert P. Harrison, Registrar

Burial Permits Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1923, to Aug 31, 1923, that I last saw her alive on Aug 31, 1923, and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Pyelitis

(duration) ..... yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Septicemia Terminal

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Urine Analysis

(Signed) A. A. Weed, M. D.

..... 19.. (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Sept 3rd 1923

20 UNDERTAKER: Joseph A Farrell — ADDRESS 2319 Dunbar St

N.B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should be careful that all information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful that all information should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Diarrhoea & Enteritis
Patient was in hospital being
treated for gonorrheal vaginitis
and a non-infectious diarrhoea
when pyelitis developed.
A.A.W.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78770

CERTIFICATE OF DEATH.

129

D78770

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1536 E. Madison ST., 7 WARD)

2-FULL NAME George H. Stewart

(a) RESIDENCE NO. 1536 E. Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1832

7 AGE 71 Years | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ...

(b) General nature of Industry, business, or establishment in which employed (or employer) Saloon

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sarah J. Clark
(Address) 1536 E. Madison St

15 Filed SEP 2 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-31-1923

17 I HEREBY CERTIFY, That I attended deceased from 6-9-1923 to 8-31-1923, that I last saw him alive on 8-30-1923, and that death occurred, on the date stated above, at 12:10 A m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) Undetermined yrs. mos. ds.

CONTRIBUTORY (Secondary) Undetermined Nephritis

(duration) Undetermined yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. H. Carpenter, M. D.

, 19 (Address) 611 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: U S National Cemetery — DATE OF BURIAL: 9-3 1923

20 UNDERTAKER: George T. A. Gibson — ADDRESS: 473 Fairmount Av

IMPORTANT.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78771 — CERTIFICATE OF DEATH. — 49 — D78771

REGISTERED NO.

1-PLACE OF DEATH 1101 Carrollton Ave

CITY OF BALTIMORE: (No. 1101 Baltimore ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Thomas

(a) RESIDENCE NO. 1101 Carrollton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Marys Co Md

PARENTS

10 NAME OF FATHER Henry Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Marys Co

12 MAIDEN NAME OF MOTHER Susanna Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co Md

14 Informant Sister

(Address)

15 Filed SEP 3 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/2 1923.

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1921, to Sept. 2, 1923.

that I last saw h living alive on Aug. 28, 1923.

and that death occurred, ~~on the date stated above~~, at 12 20 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma right antrum.

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clipping tissue

(Signed) Arthur C Peluvase M. D.

9/2, 1923 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Morgenza St Marys Co Md — DATE OF BURIAL Sept 3 1923

20 UNDERTAKER Chas. E. Cherry & Son — ADDRESS 1400 Mosher St

N. B.—WRITE PLAINLY, with unfading ink. AGE should be stated EXACTLY. PHYSICIANS should state information should be carefully supplied. Exact statement of OCCUPATION may be properly classified. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

78772

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78772 CERTIFICATE OF DEATH. X 124 D78772

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq. Hospital ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John P. Davis, M.D.

(a) RESIDENCE NO. 117 W. 76th St. WARD New York City N. Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	Mar.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary T. Davis

6 DATE OF BIRTH (month, day, and year) 12-1-1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) New York
(State or country)

PARENTS

10 NAME OF FATHER James

11 BIRTHPLACE OF FATHER (city or town) Ireland.
(State or country)

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) unknown.
(State or country)

14 Informant Hospital Board,
(Address)

15 Filed SEP 3 - 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-2-1923

17

I HEREBY CERTIFY, That I attended deceased from 8-30-, 1923, to 7-2-, 1923, that I last saw him alive on 7-2-, 1923 and that death occurred, on the date stated above, at 8:25 A m.

The CAUSE OF DEATH* was as follows:

Ruptured, Emphysema of Gall Bladder

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) General Peritonitis V. Septicemia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 8-30-23.

Was there an autopsy? No

What test confirmed diagnosis? P. findings.

(Signed) P. D. Davis, M. D.

9/2/1923 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Brookside MD	Sept 3 1923

20 UNDERTAKER Thos. Pentz & Son

ADDRESS Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS SPACE RESERVED FOR RECORD. DATA must be complete. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

78773

D78773

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D78773

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1901 Park Ave ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Berry Manahan

(Residence in Baltimore: No. 1901 Park Ave St.: yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July (Month) ..... (Day) 1861. (Year)

7-AGE, 62 yrs. ..... mos. ..... da.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Book Keeper
(b) General nature of industry, business, or establishment in which employed (or employer): 608

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. J. Frey Manahan

11-BIRTHPLACE OF FATHER (State or Country). Ohio

12-MAIDEN NAME OF MOTHER. Sarah Ann Reese

13-BIRTHPLACE OF MOTHER (State or Country). Baltimore Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wilbur F. Manahan

(Address) 319 W Pratt St.

15-

Filed ....., 191.... ROBERT N. KRAUTER, Registrar.

SEP 9 1923 BUREAU OF VITAL STATISTICS

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Aug. 30, 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest on the same (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and from the autopsy find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(Duration) ..... yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... da.

(Signed) John Konvalinka (Coroner) M. D.

Aug 30 1923 (Address) 363 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... da. In the State ..... yrs. ..... mos. ..... da.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. Green Mount Cem

DATE OF BURIAL. Sept 3. 1923

20-UNDERTAKER John C. Mitchell

ADDRESS 1201 W Fayette St

U. S. Every item of information should be carefully supplied. AGE should be given in YEARS and MONTHS EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

#78794

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

#D78774 — 44 D78774

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mt. Washington

CITY OF BALTIMORE: (No. Pimlico Road & Roaches Lane ST.) 27th WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. David H. Jones

(a) RESIDENCE. NO. Pimlico Rd. & Roaches Lane ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word): Married

6 If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Annie C. Jones.

6 DATE OF BIRTH (month, day, and year): 2/23/1855

7 AGE: Years 68 Months 6. Days 8. If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter. 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co. Md.

PARENTS

10 NAME OF FATHER: Isaac Jones.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Eliza Cushion

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Annie C. Jones. Pimlico Rd. & Roaches Lane

15 Filed SEP 3 - 1923 ROBERT A. KRAUTER. Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 1st 1923

17 I HEREBY CERTIFY, That I attended deceased from 18 May 1923, to 1st Sept. 1923, that I last saw him alive on May 31st, 1923, and that death occurred, on the date stated above, at 6.20 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Clinical findings

(Signed) Isaac W. Byerly, M. D.

9/1, 1923 (Address) 749 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden

DATE OF BURIAL: 9/3. 1923

20 UNDERTAKER: J. Hall Davis

ADDRESS 3307 Paine St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78775

CERTIFICATE OF DEATH.

49 D78775

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1604 Ruxton Ave. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie L Doherty

(a) RESIDENCE No. 1604 Ruxton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Doherty

6 DATE OF BIRTH (month, day, and year) June 4 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Doran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Hyne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Ella A Doran (Address) 1604 Ruxton Ave

15 Filed SEP 3 1923, 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31st 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1923, to Aug 31st, 1923

that I last saw h alive on Aug 30, 1923

and that death occurred, on the date stated above, at 7a m.

The CAUSE OF DEATH* was as follows:

Cancer of Uterine and all the Abdominal organs

(duration) yrs. 4 mos. 0 ds.

CONTRIBUTORY (Secondary) Sound

(duration) yrs. 4 mos. ds.

18 Where was disease contracted, if not at place of death? At Place of Death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Xray Pathology

(Signed) Arthur Williams, M. D.

, 19 (Address) Elk Ridge Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cem	Sept 3 1923
20 UNDERTAKER	ADDRESS
George A Farley	1800 W. Fayette

MATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78776

CERTIFICATE OF DEATH.

159-002 D78776

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3639 Ash St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard A. Pearson

(a) RESIDENCE. No. 3639 Ash St. Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 19-1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Pearson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Claude Ennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Mrs Claude Pearson 3639 Ash St

15 Filed SEP 3 - 1923, 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1923, to Sept 2, 1923, that I last saw him alive on Sept 1- 1923, and that death occurred, on the date stated above, at 3.45 a.m.

The CAUSE OF DEATH* was as follows:

Patent Foramen Ovale

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physician

(Signed) C. F. Hodgkin, M. D.

Sept 2, 1923 (Address) 3701 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvert Cemetery	Sept 5 1923
20 UNDERTAKER	ADDRESS
William J. Higgins	3624 Ash St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78777

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1113 D78777

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 Curtis Ave St.: 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Gamorting

(a) RESIDENCE. No. 1411 Curtis Ave ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Mar 16/18

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salts Md

PARENTS

10 NAME OF FATHER Joseph Gamorting

11 BIRTHPLACE OF FATHER (city or town) (State or country) Courtuo

12 MAIDEN NAME OF MOTHER Marie Rolandet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Courtuo

14 Informant Joseph Gamorting (Address) 1411 Curtis Ave

15 Filed SEP 3 1923 ROBERT A. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 21, 1923, to Sept 1, 1923

that I last saw h[illegible] alive on Sept 1, 1923

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Gastro enteritis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) acidosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon D Horica M. D.

(Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	Sept 3 1923

20 UNDERTAKER Frank Crockett ADDRESS 1906 Eastern Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78778

CERTIFICATE OF DEATH.

90 D78778

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 827 N. Bradford ST.: 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Stach

(a) RESIDENCE. NO. 827 N. Bradford ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Stach

6 DATE OF BIRTH (month, day, and year):

7 AGE — Years: 60 — Months: — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sailor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

080

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: John Stach

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Emma Poptia

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Anna Stach (Address) 827 N. Bradford St

15 Filed ..... 19.. Registrar

SEP 3 - 1923 ROBERT R. KRAUTER Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 2 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1 1923 to Sept 2 1923.

that I last saw him alive on Sept 1, 1923.

and that death occurred, on the date stated above, at 10.30 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

5

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): with Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

Signed: Fred Taussig M. D.

9-5-1923 (Address) 700 N. Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: Sept 5 1923

20 UNDERTAKER: Frank Crackon — ADDRESS: 1916 Eastern Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78779

CERTIFICATE OF DEATH.

X 114

D78779

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 927 Sterling ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.) N. C.

2-FULL NAME Loney Taylor

(a) RESIDENCE NO. 927 Sterling ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 8 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1915

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	8	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) N C

PARENTS

10 NAME OF FATHER Robt Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Emma Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Mrs Jennie Davis

(Address) 927 Sterling St

15 Filed SEP 3 - 1923 16 ROBERT P. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 31 1923

17

I HEREBY CERTIFY, That I attended deceased from August 30. 1923. to August 31. 1923.

that I last saw him alive on August 30. 1923.

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Convulsions + Acute Indigestion

(duration) yrs. mos. / ds.

CONTRIBUTORY (Secondary) acute Indigestion

(duration) yrs. mos. / ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dr G W Kennard, M. D.

9-1. 1923 (Address) 708 Linden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR RE- Antrim DATE OF BURIAL 9/3 1923

20 UNDERTAKER Robert F Wilkinson ADDRESS 1515 McCulloh

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Intestinal

D78780 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78780

CERTIFICATE OF DEATH. 113

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1132 Wilmer alley St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Jessie Lee Rieves

(Residence in Baltimore: No. 1132 Wilmer Alley St.; yrs., 7 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, male

4-COLOR OR RACE, colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

6-DATE OF BIRTH, June 13 1923
(Month) (Day) (Year)

7-AGE, yrs. 7 mos. 19 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Jessie Rieves

11-BIRTHPLACE OF FATHER, (State or Country), Va.

12-MAIDEN NAME OF MOTHER, Nettie Brown

13-BIRTHPLACE OF MOTHER, (State or Country), Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Nettie Rieves

(Address) 1132 Wilmer Alley

15 Filed SEP 3 - 1923 19.. ROBERT R. KRAUTER, Registrar.
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 2, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Malnutrition

(Duration) yrs. mos. ds.

(Signed) C. E. Hennessy M. D.
(Coroner.)

Sept. 2 1923 (Address) 2512 Eastern Ave City

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Carmel Cem — DATE OF BURIAL, 9-3, 1923

20-UNDERTAKER, Daniel Eaton — ADDRESS 516 Baltimore

N. B.—Every item of information should be carefully supplied. NOT wishing to be unduly particular, we repeat that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. State CAUSE OF DEATH in plain terms, so that

D78781

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78781

CERTIFICATE OF DEATH.

X/00-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. ..... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Russell Maloney

(Residence in Baltimore: No. 8 Ln. J. H. Hospital St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed or Divorced, (Write the word.)
Male	White	Single

6-DATE OF BIRTH. Jan (Month) 5 (Day) 1923 (Year)

7-AGE. ..... yrs. 7 mos. 27 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of Industry, business, or establishment in which employed (or employer)..... 0 0 0

9-BIRTHPLACE. (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Charles O'Maloney

11-BIRTHPLACE OF FATHER. (State or Country) Howard Co Md

12-MAIDEN NAME OF MOTHER. Anna Currie

13-BIRTHPLACE OF MOTHER. (State or Country). Baltimore

11-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas. Maloney

(Address) 23 Eastslup Road Dundalk

15-

Filed ..... 192.....

SEP 3 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept. (Month) 1 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 8 hrs. ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Edmon Bladen M. D.
(Coroner.)

Sept 1 1923 (Address) 1436 Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence 23 Eastslup Rd Dundalk

19-PLACE OF BURIAL OR REMOVAL, Mount Carmel DATE OF BURIAL. Sept 3 1923

20-UNDERTAKER. Henry Lutz ADDRESS 1203 N. Broadway

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78782 129 D78782

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 542 Welcome St. WARD)

2-FULL NAME Louisa Morgan

(a) RESIDENCE NO. 542 Welcome St. WARD.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married,

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of John Morgan

6 DATE OF BIRTH (month, day, and year) —— 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) King William Co
(State or country) Virginia

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unk

14 Informant John Morgan
(Address) 542 welcome st

15 Filed SEP 3 - 1923 19.. ROBERT R. KRAUSE Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug, 7, 1923, to Sept, 1, 1923, that I last saw h alive on Aug, 31, 1923, and that death occurred, on the date stated above, at 1 30 a, m.

The CAUSE OF DEATH* was as follows:

Chr. myocarditis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Depressed Nephritis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Dunc Frauchen M. D.

9/1, 1923 (Address) 122 W Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Ct DATE OF BURIAL 8/3/1923

20 UNDERTAKER Isaac L Brown & Son ADDRESS 108 W Monty

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78783

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 D78783

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH CITY OF BALTIMORE: (NO.) 734 ½ W Saratoga ST. 4 WARD)

2-FULL NAME Estella Hill

(a) RESIDENCE NO. 734 ½ W. Saratoga ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Hill

6 DATE OF BIRTH (month, day, and year): Dec 28, 1890

7 AGE — Years: 37 — Months: 8 — Days: 3 — If LESS than 1 day,.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Paris City

PARENTS

10 NAME OF FATHER: Thomas Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): N.Y.

12 MAIDEN NAME OF MOTHER: Adeline Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Estella Johnson

(Address) 734½ W. Saratoga St

15 Filed ....., 19.....

ROBERT R. KRAUTER,

Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Aug 30th 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 15 1923 to Aug. 30th 1923.

that I last saw her alive on Aug. 30th 1923.

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) Acute nephritis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum test + intubation

(Signed) James M Hayes M. D.

(Address) 543 N. Arlington Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Sept 3 1923

20 UNDERTAKER: Isaac L Brown & Son

ADDRESS: 1518 W Mont

SEP 3 1923

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78784

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78784

1-PLACE OF DEATH

City of BALTIMORE: (No. [redacted] Union Station St., 11 Ward)

Registered No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adelaide Johnson

(Residence in Baltimore: No. [redacted] St.; yrs. [redacted] mos. 1 ds.)

Boston Mass

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: F

4-COLOR OR RACE: W

5-Single, Married, Widowed, or Divorced. (Write the word.): Single

6-DATE OF BIRTH: Dont Know 1 (Month) (Day) (Year)

7-AGE: 57 yrs. — mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): Nurse

9-BIRTHPLACE. (State or Country): Gloucester Va

PARENTS

10-NAME OF FATHER: L Robinson

11-BIRTHPLACE OF FATHER. (State or Country): Va

12-MAIDEN NAME OF MOTHER: Dont Know

13-BIRTHPLACE OF MOTHER. (State or Country): Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Christophe Robinson

(Address) Boston Mass

15-Filed SEP 3 - 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH

16-DATE OF DEATH: Aug 30 [redacted] 1923. (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valv Dr. Heart

Chronic (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) [illegible] (Duration) yrs. mos. ds.

(Signed) [illegible] M. D. (Coroner)

Aug 30 1923 (Address) 1634 Druid

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Gloucester Va. DATE OF BURIAL: Sept 3 1923

20-UNDERTAKER: Robt Timmons Jr ADDRESS: 11 E. Biddle

Please fill out all items. Use ditto marks only when they will be properly understood. Do not state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78785

D78785

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. ST., 22 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward F Sites Sr.

(a) RESIDENCE NO. 403 W Pratt St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 42 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of) Widower

6 DATE OF BIRTH (month, day, and year) April 30th 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not Employed. 087

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa.
(State or country)

PARENTS

10 NAME OF FATHER P Sites

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known
(State or country)

14 Informant University Hosp. Friends.
(Address)

15 Filed ..... 19 ..... Registrar

SEP 3 - 1923

ROBERT E. KRAUTER, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 29 1923 to Sept 1 1923.

that I last saw him alive on Sept 1 1923

and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Acute & Chronic Alcoholism with Odema of the Brain

(duration) yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

Bacher (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory findings

(Signed) B. M. Rhodes M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	Sept 5 1923
20 UNDERTAKER Robt J Turner	ADDRESS 1 E Lexington St

Spec.—6-9-19—H. P. Co.—1000 Blks.

D78786

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001 D78786

REGISTERED No.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 Grantley Ave ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Elizabeth Rhode

(a) RESIDENCE. No. 615 Grantley Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	widowed.

6 If married, widowed, or divorced HUSBAND of (or) WIFE of William Henry Rhode

6 DATE OF BIRTH (month, day, and year) July 10, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work —

(b) General nature of industry, business, or establishment in which employed (or employer): Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boonsborough, Md

PARENTS

10 NAME OF FATHER David Schlosser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Elizabeth Schlosser Magdalen Susan Adams.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Beaver Creek Md.

14 Informant Nellie F. Shoemaker
(Address) 615 Grantley St.

15 Filed , 19 Registrar

SEP 3 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31st 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 18 , 1923, to Aug 31 , 1923

that I last saw her alive on Aug 31 , 1923

and that death occurred, on the date stated above, at 6:39 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension & Arteris-Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Inspection.

(Signed) Jas. E. Wells , M. D.

, 19 (Address) 521 Edmonson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Boonesboro. Md	Sept 3rd 1923

20 UNDERTAKER	ADDRESS
Joseph B. Cook	1003 W. Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78787

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

18-002 D78787

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Hospital WARD)

2-FULL NAME Louis L. Brager

(a) RESIDENCE. No. 1700 Eutaw Place, ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. 30 mos. Wilson ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Adelaide Brager

6 DATE OF BIRTH (month, day, and year) Sept. 8, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Dry Goods

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alexandria Va.

PARENTS

10 NAME OF FATHER Joseph Brager

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Isabelle Wyman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hosp Records (Address)

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1923, to Sept 1, 1923

that I last saw him alive on Sept 1, 1923

and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 27

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Howard M. Stern M. D

19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem.

DATE OF BURIAL: 9/3/ 1923

20 UNDERTAKER: David Londheim

ADDRESS 118 W. Mt. Royal Ave

CAUSE should be stated EXACTLY. PHYSICIANS should state whether DISEASE was Primary, Supposed. AGE should be stated so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78788 D78788 128

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., 8 WARD)

2-FULL NAME George W. Sheckels.

(a) RESIDENCE NO. 1680 Darley Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
	36	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Benjamin Sheckels.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary A. Hubbard.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Chris C. Sheckels, brother. (Address) 1447 William St.

15 Filed SEP 3 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 31st. 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry & autpsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy & inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis.
Alcoholism.
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Albert Rosenstock M. D.
(Coroner.)

Sept. 2nd. 1923 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL Sept 4 1923

20 UNDERTAKER William Cook — ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78789

CERTIFICATE OF DEATH.

74-001 D78789

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Y. M. C. A. (Franklin & Cathedral) ST., 11 WARD)

2-FULL NAME Edgar Parsons

(a) RESIDENCE NO. Y. M. C. A. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 28-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) Balto Credit Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Edw Parsons

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Mary Sheeler

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Elias B. Pearce
(Address) Halethorpe

15 Filed SEP 3 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Sudden (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Lee Kelly M. D.
(Coroner.)

Sept 2, 1923 (Address) 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Sept 3 1923
20 UNDERTAKER Wm Cook	ADDRESS 562 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78790

CERTIFICATE OF DEATH.

113 D78790

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 Mary Lee ST., 27 WARD) Hamilton

2-FULL NAME Marguerite Rogers

(a) RESIDENCE NO. 11 Mary Lee ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 13 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 010

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltr.
(State or country)

PARENTS

10 NAME OF FATHER Burring Rogers

11 BIRTHPLACE OF FATHER (city or town) Baltr
(State or country)

12 MAIDEN NAME OF MOTHER Hennie Liber

13 BIRTHPLACE OF MOTHER (city or town) Baltr
(State or country)

14 Informant My Father
(Address) 11 Mary Lee

15 Filed SEP 3 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 29, 1923 to Sept 1, 1923 that I last saw her alive on Sept 1, 1923 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Enteric Colitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Semple Long, M. D.

1923 Address 27 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Dale — DATE OF BURIAL 1923

20 UNDERTAKER Wm Corkran & Son ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78791

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78791

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 Hermosa Ave ST. Hamilton WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret MacCallum

(a) RESIDENCE No. 113 Hermosa Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. 9 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William MacCallum

6 DATE OF BIRTH (month, day, and year) Dec 3 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Harry S. Schutte

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Ella Trill

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant William MacCallum (Address) 113 Hermosa Ave

15 Filed SEP 3 - 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1923

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1923, to Sept 1, 1923, that I last saw h alive on Sept 1, 1923, and that death occurred, on the date stated above, at 5.15 m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) H L Wolcott M. D.

, 19 (Address) 728 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Sept 4 1923

20 UNDERTAKER William Cook — ADDRESS 502 E Mt

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS sending this CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

D78792

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

74-001 · D78792

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 Glenwood Av ST.; 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henrietta Jutsom Carman

(Residence in Baltimore: No. 615 Glenwood Av St.; 43 yrs., mos. ds)

43 yr

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Nov 12, 1864 (Month) (Day) (Year)

7-AGE. 59 yrs. 3 mos. 19 ds. If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Housewife 37
(b) General nature of industry, business, or establishment in which employed (or employer) 0

9-BIRTHPLACE. (State or Country) Hampstone Northampton Co Va

PARENTS.

10-NAME OF FATHER, Benjamin Haley

11-BIRTHPLACE OF FATHER (State or Country), Capeville Northampton Co Va

12-MAIDEN NAME OF MOTHER Patty Collins

13-BIRTHPLACE OF MOTHER (State or Country) Capeville Northampton Co Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thomas J. Carman

(Address) Same

15- Filed SEP 3 - 1923 19.. ROBERT N. KRAUTER, BUREAU OF VITAL STATISTICS Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, August 30 (Month) 31 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from August 30 1923, to Aug 31 1923, that I saw h r alive on Aug 31 1923, and that death occurred, on the date stated above, at 8:47 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
High Blood Pressure

(Duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

(Signed) S. W. Brashears M. D.

Sept 1, 1923 (Address) 521 Shenandoah

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. mos. ds. In the State 43 yrs. mos. ds.

Where was disease contracted, if not at place of death? Same

Former or usual residence Same 615 Glenwood Av

19-PLACE OF BURIAL OR REMOVAL. Loudon Park Sept. 3 1923 DATE OF BURIAL, 19..

20-UNDERTAKER W M Cole ADDRESS 522 E Lan

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78793

CERTIFICATE OF DEATH.

90 D78793

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1830 N. Dallas ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Bertha C. Scroggs

(a) RESIDENCE NO. 1830 N. Dallas ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of James L. Scroggs

6 DATE OF BIRTH (month, day, and year) June 10 - 1810

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore County

PARENTS

10 NAME OF FATHER Gebulon T. Barbour

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore County

12 MAIDEN NAME OF MOTHER Diliah Barbour

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co

14 Informant Wm. W. Barbour

(Address) 1434 N. Bond

15 Filed SEP 3 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug-29 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 1- 1923 to Aug-29 1923.

that I last saw her alive on Aug-29-1923

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E. Gill Hall, M. D.

Aug 31 1923 (Address) 1631 E. North Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hiss M E Cemetery Harford Rd	9/4 1923
20 UNDERTAKER	ADDRESS
George J Ruth	1755 Harford Av

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78794

CERTIFICATE OF DEATH.

161-001

D78794

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4911 Eastern Ave ST.: 76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred Clark

(a) RESIDENCE. No. 4911 Eastern Ave ST.: — WARD.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 hours How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — — —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than ~~1 day~~, 2 hrs. or ..... min.
	2 hours			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 4911 Eastern ave Baltimore Maryland.

PARENTS

10 NAME OF FATHER Albert Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Annie Weber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Parents (Address) 4911 Eastern Ave

15 Filed SEP 3 - 1923 19 ROBERT P. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31st 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 30th, 1923, to Aug 31st, 1923, that I last saw her alive on Aug 31st, 1923, and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. ~~mos.~~ 2 hours ~~ds.~~

CONTRIBUTORY (Secondary) (duration) — yrs. — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Adam Tod. M. D.

. 19 (Address) 4704 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Schwartz Cem.	Sept 3 1923
20 UNDERTAKER Lilly & Zeiler	ADDRESS 103 S. W. St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

~~D78795~~ 66618 ~~D78795~~

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

113 D78795

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 17 WARD)

2-FULL NAME Hortense Morallis.

(a) RESIDENCE NO. 1117 Pennsylvania Ave ST., City WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND~~ of ~~(or) WIFE~~ of

6 DATE OF BIRTH (month, day, and year) May 22, 1923.

7 AGE: Years —; Months 3; Days 9; If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Emanuel Morallis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Spain.

12 MAIDEN NAME OF MOTHER Edith Moore.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant JOHNS HOPKINS HOSPITAL Records

(Address)

15 Filed SEP 3 - 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 27, 1923, to Sept 1, 1923, that I last saw her alive on Sept 1, 1923, and that death occurred, on the date stated above, at 3:00 A. m.

The CAUSE OF DEATH* was as follows:

Vomiting and Diarrhoea (not dysentery)

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) H. H. Mitch M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem. — DATE OF BURIAL: Sept 3 1923

20 UNDERTAKER: Thos J. G. Locke — ADDRESS: 1302 Jefferson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

D78796

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D78796

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 103 Edgedale Ave. Brooklin Park St., 24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME....Emma S. Householder

(a) Residence No.....1345 Jackson St. St.,.....Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. Householder

6-DATE OF BIRTH (month, day and year): Aug. 4, 1866

7-AGE: 57 yrs. mos. 28 ds. If LESS than 1 day, hrs. or. min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: House_work at

(b) General nature of industry, business, or establishment in which employed (or employer): home.

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Arundel Co.

PARENTS.

10-NAME OF FATHER: John N. Hands

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Washington D.C.

12-MAIDEN NAME OF MOTHER: Emma C Carroll

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Washington D.C.

14-

(Informant) Wm. Householder

(Address) 1345 Jackson St.

15-

Filed SEP 3 1923 ROBERT R. KRAETER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 9-1-1923

17- I HEREBY CERTIFY, That I attended deceased from 1.20.23, 19..., to 9.1.23, 19..., that I last saw h-e alive on 9.1.23, 19..., and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of 1.22.23

Was there an autopsy? no

What test confirmed diagnosis? Microscopic

(Signed) R. A. Fowler M. D.

9.3.23 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: sept 4, 1923

20-UNDERTAKER: Elmer W. Conklin — ADDRESS 924 E Eager

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See instructions on back of certificates.

CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

Additional Space for Further Statements by Physician.

Of the Ulcers

Spec.—6-9-19—H. P. Co.—1000 Bks.

078797

HEALTH DEPARTMENT—CITY OF BALTIMORE

078797

CERTIFICATE OF DEATH.

Public 31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 Quad Ave. St. 27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie L McCoy.

(a) RESIDENCE. No. 114 Quad Ave. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fmale.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Hilard H McCoy.

6 DATE OF BIRTH (month, day, and year) Augs 25 - 1890

7 AGE — Years: 33 — Months: — Days: 7 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Michael Dorsey.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Bessie C. Coyne

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Royal P Dorsey.
(Address) 114 Quad ave.

15 Filed SEP 3 - 1923, 19.. ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1923

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1921, to Sept 2, 1923, that I last saw h.. alive on Sept 2, 1923, and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs.

2 (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H D McCoy M. D.

9/2, 1923 (Address) Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Sept 5 1923

20 UNDERTAKER: William Cook — ADDRESS: 502 E Nash

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78798

CERTIFICATE OF DEATH.

90 D78798

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 347 E 22nd St. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Alexander

(a) RESIDENCE. No. 347 E 22nd St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Laura B. Alexander

6 DATE OF BIRTH (month, day, and year) Oct 24 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Life Insurance

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hariet Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Laura B. Alexander
(Address) 347 E 22nd St.

15 Filed SEP 3 1923 ROBERT R. KRAMER, Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-2 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1923, to Sept 2, 1923, that I last saw him alive on Sept 2, 1923, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secandary) Cystitis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Harris Friedman, M. D.

, 19 (Address) 2601 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rock Spring Md	Sept-5 1923
20 UNDERTAKER	ADDRESS
Wm Cook	502 E N. Ave.

Information should be carefully supplied. AGE should be stated EXACTLY. FIRST NAME should be given in full. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78799

CERTIFICATE OF DEATH.

129 D78799

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2027 N. Calvert ST., 17 WARD)

2-FULL NAME Charles Wesley Addison

(a) RESIDENCE NO. 2027 N Calvert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Jane

6 DATE OF BIRTH (month, day, and year) Dec. 7 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bookkeeper 008

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Strouse Bros

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wm Addison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A Crumbaugh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Mary Addison (Address) 2027 N Calvert

15 Filed SEP 3 - 1923 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31 1923

17

I HEREBY CERTIFY, That I attended deceased from August 27th, 1923, to August 31st, 1923, that I last saw him alive on August 30th, 1923, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Urinary.

(Signed) Wm Conrad Bobb, M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Sept 5 DATE OF BURIAL 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E. A. Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Oettinger

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78800

CERTIFICATE OF DEATH.

X 149

D78800

1-PLACE OF DEATH Church Home and Infirmary

REGISTERED NO.

CITY OF BALTIMORE: (.....ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Oettinger

(a) RESIDENCE NO. Kinston N.C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Oettinger

6 DATE OF BIRTH (month, day, and year) Feb 12 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	76	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edwin Oettinger

(Address) Kinston N.C.

15 Filed SEP 3 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 16, 1923, to Sept 3, 1923, that I last saw h.. alive on Sept 3, 1923, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Method

(Signed) Cayetano Paulteres M. D.

, 19 (Address) Church Home and Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Kinston N.C.	9/3—1923
20 UNDERTAKER	**ADDRESS**
David Goodheim	118 W. Lombard St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should read CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78801

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

101 - 001 D78801

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 843 N. Montford Ave. ST., 2 WARD)

2-FULL NAME Antonetta C. Hobletzell

(a) RESIDENCE No. 843 N. Montford Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) ~~WIFE~~ of F. Hobletzell

6 DATE OF BIRTH (month, day, and year) Oct-6-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	72	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) at Home (3)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Chas. Franz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotte L

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Arthur P. Hobletzell

(Address) 843 N. Montford

15 Filed SEP 3 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1 1923

17 I HEREBY CERTIFY, That I attended deceased from August 25, 1923, to Sept 1 — 1923, that I last saw h[illegible] alive on Aug 31 — 1923, and that death occurred, on the date stated above, at 3 45 P. m.

The CAUSE OF DEATH* was as follows:

Pleuro-Pneumonia (Left)

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Jno. A. Brauer, M. D.

, 19 (Address) 125 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cem.	Sept 4 1923
20 UNDERTAKER Philip Herwig	ADDRESS 2046 Orleans St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78802

CERTIFICATE OF DEATH.

129 D78802

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 N. East Ave - ST., 70 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albertha Becker

(a) RESIDENCE No. 13 N. East Ave - ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 33 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of Geo. L. Becker

6 DATE OF BIRTH (month, day, and year) Sept. 23-1889

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John L. Stump

11 BIRTHPLACE OF FATHER (city or town) City (State or country)

12 MAIDEN NAME OF MOTHER Susan A. —

13 BIRTHPLACE OF MOTHER (city or town) City (State or country)

14 Informant Geo. L. Becker

(Address) 13 N. East Ave -

15 Filed SEP 3 - 1923 19... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1923, to Sept 1, 1923, that I last saw her alive on Aug 31, 1923, and that death occurred, on the date stated above, at 5-50 A m.

The CAUSE OF DEATH* was as follows:

Chr. Int. Nephritis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) E B Britton, M. D.

Sept. 1923 (Address) 1711 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem.	Sept 5 1923
20 UNDERTAKER	ADDRESS 2016
Philip J. Hennig	Orleans St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

164959 D78803

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 D78803

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL.

CITY OF BALTIMORE: (No. " " " ST., 9 WARD)

2-FULL NAME William Fehle.

(a) RESIDENCE NO. 1644 Hilton Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. 3 mos. 8 ds. How long in U. S., if of foreign birth? 52 yrs. 3 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 23rd 1871.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
52	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 062

(b) General nature of industry, business, or establishment in which employed (or employer) Clothing House

(c) Name of employer Philip Rabin bx.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Fehle.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant JOHNS HOPKINS HOSPITAL. (Address) Records.

15 Filed SEP 3 - 1923 ..... 49 ROBERT N. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 31, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1923, to Aug 31, 1923.

that I last saw him alive on Aug 31, 1923.

and that death occurred, on the date stated above, at 11^40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung.

Metastasis to glands of neck + mediastinum

(duration) yrs. 9 mos ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) Chas. R Bugg, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Sept 4th 1923
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN's medical
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78804

CERTIFICATE OF DEATH.

91-002

D78804

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 152 Mc. Phail ST., 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonard Dunner

(a) RESIDENCE NO. 152 Mc. Phail ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? 50 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Caroline Dunner

6 DATE OF BIRTH (month, day, and year) JAN-17-1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Lenard Dunner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geo. Dunner (Address) 2252 Frederick Ave

15 Filed SEP 3 - 1925 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 30th 1925

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1920, to Aug 30, 1925, that I last saw him alive on Aug 30th, 1925, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows: Senile Arterio Sclerosis

— mo (duration) 3 yrs — mos — ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) 1 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical Ex

(Signed) Henry E. Ohle M. D.

, 19 (Address) 1203 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 3 19

20 UNDERTAKER F. B. Wagner ADDRESS 2256 Fred'k Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

D78805

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

D78805

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 2126 Hollins St. St., 20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ferdinand Bruns,

(a) Residence No. 2126 Hollins St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Johanna M. Bruns

6-DATE OF BIRTH (month, day and year) Dec. 16, 1851

7-AGE.	If LESS than 1 day,
71 yrs. 8 mos. 23 ds.	....hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Shoe Cutter

(b) General nature of industry, business, or establishment in which employed (or employer): Of

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Bernard P. Bruns.

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Catherine Snearlin

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-

(Informant) Mrs. Johanna M. Bruns

(Address) 2126 Hollins St.

15-Filed SEP 3 - 1923 ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 2. 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug. 12, 1923 to Sept. 2, 1923

that I last saw h— alive on Sept. 1 1923

and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Hypocondilis.

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac collapse

(Duration) yrs. 1 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edward Mayerberg M. D.

9/3/23 (Address) 248 Fulton Ave

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
New Cathedral	9/4/23

20-UNDERTAKER	ADDRESS
Geo. L. Schwab	210 Frederick Ave

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bkn. 78806

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78806

CERTIFICATE OF DEATH.

188-003

D78806

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Henning.

(a) RESIDENCE No. 13 E. West St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Widow.

5a If married, widowed, or divorced, husband of

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Furlong.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Johanna ----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Florence Wayson. (daughter)
(Address) 936 Hanover St.

15 Filed SEP 4 1923 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 1st. 1923. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of the skull.
Struck by an automobile.
Accidental death.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Otto Reinhardt M. D.
(Coroner.)
Sept. 3rd. 1923 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? Accident Hanover & Pinder Sts.

Former or usual residence September 1st. 1923.

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cem. DATE OF BURIAL Sept 4 1923

20 UNDERTAKER Maynard S. Flynn ADDRESS 1422 Light St.

FROM is very important. See instructions on back of certificate. Exact statement of OCCUPATION may be properly Classified.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78807

CERTIFICATE OF DEATH.

161-001 D78807

1-PLACE OF DEATH 100 N. Patterson Pk. Ave 6

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Louis Forster.

(a) RESIDENCE NO. 100 N. Patterson Pk. Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. — mos. — ds. — How long in U. S., if of foreign birth? 0 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 3, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or ..... min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Arthur R. Forster

11 BIRTHPLACE OF FATHER (city or town) Balto, (State or country) Md.

12 MAIDEN NAME OF MOTHER Alvina C. Podvoil

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Arthur R. Forster (Address) 100 N. Patterson Pk. ave.

15 Filed SEP 4 - 1923 ROBERT R. KRAUTER Registrar

Burial Permit Check.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 3, 1923, to ....., 19..., that I last saw him alive on Sept. 3, 1923 19..., and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Premature delivery.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) L. C. Solibal, M. D.

, 19 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL Sept. 4 1923

20 UNDERTAKER Jos. J. Herr — ADDRESS 156 N. Luzerne

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78808

D78808

CERTIFICATE OF DEATH. 162

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 Dos. Yorp ST., 16 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Erb

(a) RESIDENCE NO. 1024 Patterson Park ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 9/1/23

7 AGE — Years — Months — Days one — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Arthur Erb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Eliz Schopp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs Draught

(Address) 203 E Pleasant St

15 Filed ....., 19 ..... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

SEP 4 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923 to Sept 1, 1923, that I last saw he alive on Sept 1, 1923, and that death occurred, on the date stated above, at 9.15 m.

The CAUSE OF DEATH* was as follows:

Asphyxia (pallida) Neonatorum

(duration) ... yrs. ... mos One ds.

CONTRIBUTORY (Secondary) none

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? at Place death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Mr T Draught M. D.

9/3, 1923 (Address) 203 E Pleasant St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL Sep 4 1923

20 UNDERTAKER Henry Knecht & Son — ADDRESS 1301 E Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78809 10 D78809

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (St.) (Ward)

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine M. Gessler

(a) RESIDENCE No. 2033 Sinclair Lane ST. ..... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Aug 13 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto.
(State or country) md

PARENTS

10 NAME OF FATHER Raymond Gessler

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Lotty Dare

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Raymond G. Gessler
(Address) 2033 Sinclair Lane

15 Filed ..... 19 ..... ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1923, to Sept 3, 1923, that I last saw her alive on Sept 3, 1923, and that death occurred, on the date stated above, at 11:25 a m.

The CAUSE OF DEATH* was as follows:

diphtheria, nasal, bacillus - pharyngeal

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) myocarditis

(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Wallace Swan M. D.

9/3/23 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Sept 4 1923
20 UNDERTAKER	ADDRESS
Gessler & Gessler	1737 Eager

SEP 4 1923

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied.

Spec.—1-10-21—M&T—1500 Bks.

D78810

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78810

90

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5304 St Charles Ave ST., 27 WARD)

2-FULL NAME Ella J Gephardt.

(a) RESIDENCE NO. 5304 St Charles ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 16th 1862.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry Murphy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Annie McCarty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) John Gephardt 5304 St Charles Ave

15 Filed SEP 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1923, to Sept 2, 1923, that I last saw her alive on Sept 1, 1923, and that death occurred, on the date stated above, at 9.45 a m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Kidney Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease (duration) 2 yrs mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) A. O'Leary M. D.

Sept. 4 1923 (Address) 3901 Harrison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL Sept 5 1923

20 UNDERTAKER Roff & Turner

ADDRESS 1442 E Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78811

CERTIFICATE OF DEATH.

15-00 ✓ D78811

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1910 Barclay ST.; 12 WARD)

REGISTERED No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Josephine ~~Charlotte~~ Henderson Jordan

(Residence in Baltimore: No. 1910 Barclay St.: 25 yrs.. mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH. Sept 20, 1843 (Month) (Day) (Year)

7-AGE. 79 yrs. 11 mos. 12 ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer). 0

9-BIRTHPLACE, (State or Country). Portsmouth. Va

PARENTS.

10-NAME OF FATHER. Gerard Henderson

11-BIRTHPLACE OF FATHER (State or Country). Va.

12-MAIDEN NAME OF MOTHER Mary J Reynolds

13-BIRTHPLACE OF MOTHER (State or Country). Va

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. H. Jordan

(Address) 1910 Barclay St

15- SEP 4 1923 ROBERT R. KRAUTER BURIAL PERMIT CLERK

Filed ....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 1st, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Aug 30th 1923, to Sept 1st 1923, that I saw her alive on Aug 30th 1923, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Exhaustion

Has been paralyzed since May 1919

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Old age

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

....., 191... (Address) 833 N Fulton Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL, OR REMOVAL. Portsmouth. Va

DATE OF BURIAL. Sept 3., 1923

20-UNDERTAKER Wm. J Tickner & Sons

ADDRESS N & Va

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

078812 46 078812

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella West

(a) RESIDENCE NO. 14 W. Chase ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
~~Husband of~~ (or) WIFE of Richmond West

6 DATE OF BIRTH (month, day, and year) May 26-1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis
(State or country) Maryland.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Mary Brewer

13 BIRTHPLACE OF MOTHER (city or town) Annapolis
(State or country) Maryland

14 Informant Richmond West
(Address) 14 West Chase St

15 Filed SEP 4 - 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 1. 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 25 1923, to Sept. 1, 1923.

that I last saw her alive on Sept. 1, 1923

and that death occurred, on the date stated above, at 2.00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Cervical)

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & Clinical findings

(Signed) Wm. J. Fulton, M. D.

, 19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. Use reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Lawn Cem DATE OF BURIAL Sept 4, 23

UNDERTAKER Samuel Hawley Waddle ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Size 6-9-19—H. P. Co.—1000 Bks.

D78813

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78813

CERTIFICATE OF DEATH. 113

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2731 Fox ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hattie Elizabeth Smith

(a) RESIDENCE. No. 2731 Fox ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. 9 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: fem

4 COLOR OR RACE: col,

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 28-22

7 AGE — Years | Months: 9 | Days: 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: baby
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Jarrett Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Virginia A. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Jarrett Smith 2731 Fox st

15 Filed SEP 4 - 1923 16 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 2nd, 1923, to Sept 3rd, 1923, that I last saw her alive on Sept 3rd, 1923, and that death occurred, on the date stated above, at 11:10 a.m.

The CAUSE OF DEATH* was as follows:
Cholera Infantum

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2731 Fox

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Only history & symptoms

(Signed) D. Garrett, M. D.

1923 (Address) 3514 W. Baltimore st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cemetery City — DATE OF BURIAL: Sept 4 1923

20 UNDERTAKER: Frank Hensley — ADDRESS: Belle

REMARKS: Should be filled in carefully and legibly. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78814

CERTIFICATE OF DEATH.

102 D78814

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Sq Hospt. ST., 15 WARD)

2-FULL NAME Mr John L Gass

(a) RESIDENCE NO. 1325 N Fulton ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Nellie Gass

6 DATE OF BIRTH (month, day, and year) Jan. 29, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	1	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 0.50

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer self

9 BIRTHPLACE (city or town) Balto.
(State or country) Maryland.

PARENTS

10 NAME OF FATHER August Gass

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia ?

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Nellie A. Gass
(Address) 1325 N. Fulton Ave.

15 Filed SEP 4-1923 19.... Registrar

ROBERT R. KRAUTER,

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 3 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 2, 1923, to Sept 3, 1923, that I last saw him alive on Sept 2, 1923, and that death occurred, on the date stated above, at 11:10 A m.

The CAUSE OF DEATH* was as follows:

Hem. thorax following lung abscess -

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Sept-3-23

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N. I. Parr - per RS Evans M. D.

9/3, 23 (Address) Franklin Sq Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Sept 6 1923
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 W Balto

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of.....
(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Not tuberculous

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78815

CERTIFICATE OF DEATH.

80 D78815

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417 Glenedward Ave. Ward)

(If death occurred in hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edona May Cooper

(a) RESIDENCE. NO. 417 Glenedward Ave. Ward

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Feb 2. 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	✓	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Walter Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Blanch Yowd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Walter Cooper (Address) 417 Glenedward Ave

15 Filed SEP 4 - 1923, 19 ROBERT N. KRAMER, Registrar, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 30, 1923, to Sept 3, 1923, that I last saw her alive on Sept 3, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Convulsions (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diarrhoea (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. A. Richardson, M. D.

Sept 3 1923 (Address) 112 N. 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional apace.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Sept 3 1923

20 UNDERTAKER ADDRESS

Chenowith & Son Chestnut Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78816

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓ D78816

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 835 W. 35 St ST. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry S. Stabler

(a) RESIDENCE No. 835 W 35 St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary E. Stabler

6 DATE OF BIRTH (month, day, and year) Apr 15-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	70	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer) Pat Veryon

(c) Name of employer Colton Duck Mills

9 BIRTHPLACE (city or town) (State or country) Balto Co

PARENTS

10 NAME OF FATHER Henry Stabler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co

12 MAIDEN NAME OF MOTHER Matilda Buck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co

14 Informant Mr Geo. Stabler

(Address) 835 W 35 St

15 Filed ..... 19 ..... ROBERT R. KRAUTER Registrar

SEP 4 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9. 3, 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Sept 3, 1923, that I last saw him alive on Sept 3, 19..., and that death occurred, on the date stated above, at 9-30 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) [illegible] M. D.

9/4, 1923 (Address) 5429 Charlestown Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys, Md DATE OF BURIAL Sept 5 '23

20 UNDERTAKER A. S. Marshall ADDRESS 353 Gilford Rd

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78817

44 D78817

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 515 N Mount ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Brown

(a) RESIDENCE NO. 515 N Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced (or) WIFE of Robert Brown

6 DATE OF BIRTH (month, day, and year) — — 1868

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Essex County Va

PARENTS

10 NAME OF FATHER Henry Tyndall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Essex Co Va

12 MAIDEN NAME OF MOTHER Mary Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Essex County Va

14 Informant Robert Brown (Address) 515 N Mount

15 Filed SEP 4 1923 ROBERT H. ARNOLD Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from July 23, 1923, to Sept 1, 1923, that I last saw h[illegible] alive on Aug 29, 1923, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Hepatic Malignancy

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. J. Cogill M. D.

(Address) 119 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL Sept 4 1923

20 UNDERTAKER Mrs R. C. Elliott — ADDRESS Parkton Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78818 — 31 — D78818

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2506 Rayner Ave St. 16 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Cure

(a) RESIDENCE NO. 2506 Rayner Ave; ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 6-1897.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .....min.
	25	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Howard Co., (State or country) Md.

PARENTS

10 NAME OF FATHER Levin Cure

11 BIRTHPLACE OF FATHER (city or town) — (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Hall

13 BIRTHPLACE OF MOTHER (city or town) — (State or country) Md.

14 Informant Martha Cure
(Address) 2506 Rayner Ave.

15 Filed SEP 4 1923 ROBERT R. KRAUTER Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 1 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1- 1921, to Sept 1- 1923, that I last saw him alive on August 31- 1923; and that death occurred, on the date stated above, at 8:55 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) — yrs. — mos. 15 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum

(Signed) Chester Riland, M. D.

9-1-. 1923 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 4 1923
20 UNDERTAKER	ADDRESS
Mrs. R. C. Elliott	1722 Eastlands.

MATTER should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78819

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 D78819

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 16 WARD)

2-FULL NAME Maggie Jenkins

(a) RESIDENCE NO. 1307 Riggs Ave. ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) South River
(State or country) Maryland.

PARENTS

10 NAME OF FATHER B. Gibson

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER C. Boston

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14 Informant Bayview Hospital Records
(Address)

15 Filed SEP 4 1923, 19 ..... Registrar
ROBERT R. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 19 23

17

I HEREBY CERTIFY, That I attended deceased from Aug 20, 1923, to Sept. 1, 1923, that I last saw her alive on Sept 1, 1923, and that death occurred, on the date stated above, at 6.00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Cervical)

..... (duration) ..... yrs. 8 mos ..... ds.

CONTRIBUTORY .....
(Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes:

What test confirmed diagnosis? Autopsy Clinic findings

(Signed) Wm. F. Faulton, M. D.

, 19 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 9/4. 1923

20 UNDERTAKER James H. Dennis — ADDRESS 3[illegible] Eastern

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Minor

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78820

CERTIFICATE OF DEATH.

100-001 D78820

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.....

CITY OF BALTIMORE: (No. ..... ST.: 5 ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alex Minor

(a) RESIDENCE. NO. 1231 St. Mathews ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: M

5 Single, Married, Widowed, or Divorced (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 2 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Louis Minor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis Cohen

(Address) 1231 St Mathews St

15 Filed ..... 19 SEP 4 - 1923 ROBERT R. KRAMER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/3 1923

17 I HEREBY CERTIFY, That I attended deceased from 9/1, 1923, to 9/3, 1923, that I last saw him alive on 9/3, 1923, and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis 1 ds.
(duration) yrs. mos.

CONTRIBUTORY (Secondary) Pneumonia 3 ds.
(duration) yrs. mos.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical & Lab.

(Signed) Jos. C. Weber M.D.

, 19 (Address) Hebrew Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Hebrew Rem	9/4 1923
20 UNDERTAKER	ADDRESS
Jack Leder	1439 E Baltimore St

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma,""Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage,""Inanition,""Marasmus,""Old age,""Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Bronchs

D78821

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78821

CERTIFICATE OF DEATH.

113

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 1139 N. Gilmor St. 11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Wesley Arthur

(Residence in Baltimore: No. 1139 N. Gilmor St.; 1 yrs., ... mos. 13 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	colored	single

6-DATE OF BIRTH. Aug. 20 1922
(Month) (Day) (Year)

7-AGE. 1 yrs. ..... mos. 13 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... 0

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Laurence Arthur

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Kathryn Wilson

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laurence Arthur

(Address) 1139 N. Gilmor St.

15-

Filed SEP 4 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 2, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cirrhosis

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) U.D. Cirrhosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Sept. 3, 1923 (Address) 28 W. Lanvale St.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death..... yrs. ..... mos. ..... ds. In the State..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	Sept 4 1923

20-UNDERTAKER.	ADDRESS
Saml H. Cook Son	1400 Mosher

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec– 12-23-21—E.B.P.S.—400 Bks.

D78822

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78822

CERTIFICATE OF DEATH.

X 31

1-PLACE OF DEATH

Registered No. 6093

City of BALTIMORE: (No. Municipal Tubercular Hospital 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. Lesner

(a) Residence No. Lansdowne Md. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6-DATE OF BIRTH (month, day and year)

7-AGE, 25 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Enamel Burner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

886

9-BIRTHPLACE (city or town) (State or Country), Maryland

PARENTS

10-NAME OF FATHER, Nicholas Lesner

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Annie Roth

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md.

14- (Informant) Patient

(Address) Lansdowne Md.

15- Filed SEP 4 1923 ROBERT R. KRAUTER, Registrar.

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9-1-23

17- I HEREBY CERTIFY, That I attended deceased from April 23 19 23 to Sept 1 19 23

that I last saw h. im alive on Sept 1 19 23

and that death occurred, on the date stated above, at 9.00 p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum & X-ray

(Signed) W. A. Lally M. D.

19 (Address) Municipal TB Hospital

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St Matthews Cem

DATE OF BURIAL. Sept 4th 19 23

20-UNDERTAKER. A. Jones

ADDRESS 111 S. Gilmor St

Should be carefully supplied. Age should be stated in plain terms, so that it may be properly classified. See instructions on back of certificates. Exact statement of OCCUPATION is very important.

Cor.—1-12-23—M&T—100 Bks.

D78823

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-007 D78823

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 15th & Gough ST., 7 WARD)

2-FULL NAME John M. Bishop

(a) RESIDENCE NO 530 N. Elwood ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	~~Married~~ Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ~~Mary Bishop~~

6 DATE OF BIRTH (month, day, and year) Nov 16th 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	37	9	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Foreman of Laborers
(b) General nature of industry, business, or establishment in which employed (or employer) Bethlehem Steel Co
(c) Name of employer Alabama

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER John Bishop

11 BIRTHPLACE OF FATHER (city or town) Ala.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Ala
(State or country)

14 Informant Mary Kriner
(Address) 530 N. Elwood St

15 Filed SEP 4 - 1923, 192 ..... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2nd 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest Inquiry thereon and from the evidence obtained by said Inquest, aforesaid find that said deceased came to his death on the day stated above.
(Inquest or inquiry.)
The CAUSE OF DEATH was as follows: Fractured Skull

CONTRIBUTORY (Secondary) ~~Supposed to have been~~ Struck by Street car (duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos. B. Horton, M. D.
(Coroner.)
Sept 4 1923 (Address) Curtis Bay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fort Deposit Alabama — DATE OF BURIAL Sept 4 1923

20 UNDERTAKER Wm Cook — ADDRESS 502 E North Ave

CAUSE OF DEATH to be filled in by physician. Note that it may be necessary to obtain information from persons other than physician. See instructions on back of certificate.
TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78824

CERTIFICATE OF DEATH.

X 129 D78824

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt. Geil Hosp. ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adam Cook

(a) RESIDENCE NO. Sykesville Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Louise Cook

6 DATE OF BIRTH (month, day, and year) 6/6/1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hospital Attendant

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer: Springfield Hosp.

9 BIRTHPLACE (city or town) (State or country): Wilmington Del.

PARENTS

10 NAME OF FATHER: Walter Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Delaware

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Louise Cook

(Address): Sykesville Md

15 Filed SEP 4 - 1923 ROBERT R. KRAUTER, Registrar, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-4-1923

17

I HEREBY CERTIFY, That I attended deceased from 9-2-23 19 , to 9-4-23 , 19 ,

that I last saw h~~im~~ alive on 9-4-23 , 19 ,

and that death occurred, on the date stated above, at 8:15 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Chr Syphilis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dil Cardiac

(duration) yrs. mos. 1/2 hour

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Geo C Thompson M. D.

, 19 (Address) Mt Geil Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sykesville Md.

DATE OF BURIAL: Sept 6 1923

20 UNDERTAKER: Jas. R. Weer

ADDRESS: Sykesville Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

Woolschleger ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78825 38 D78825

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1106 S. Lakewood ave St., 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Ellen Woolschleger

(a) Residence No. 1106 S. Lakewood ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. 20 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE, W.

5-Single, ~~Married, Widowed,~~ or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1st Nov. 1. 1897

7-AGE. 25 yrs. 10 mos. ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) 10

(c) Name of employer 0

9-BIRTHPLACE (city or town) (State or Country), Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Frederick Woolschlege.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto. Md.

12-MAIDEN NAME OF MOTHER, Lottie Pfeifer.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14- (Informant) Lottie Woolschleger

(Address) 1106 S. Lakewood ave

15-

Filed ..... 192.....

SEP 4 - 1923

ROBERT N. KRAUTER, Burial Permit Registrar. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 2 - 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug. 28 1923 to Sept 2, 1923

that I last saw h[illegible] alive on Sept 2, 1923

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Fever

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY, (Secondary) Broncho-Pneumonia hypostatic

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Lumbar Puncture —

What test confirmed diagnosis?

(Signed) Louis A. W. Krause M. D.

19 (Address) 2500 E. Madison St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Carmel Cemetery

DATE OF BURIAL. Sept. 5 1923

20-UNDERTAKER. Zinkler + Zinkler

ADDRESS 1739 E. Eager St.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78826

CERTIFICATE OF DEATH.

24-001

D78826

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1000 N Charles ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Cleves Wilkins

(a) RESIDENCE No. 1000 N Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or Divorced. (write the word): Single

5a If ~~married~~, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 3rd 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	67	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Dr Josepha Wilkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Anne C. Pleasent

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Mrs H B. Snowden (Sister)

(Address) 216 E Biddle St

15 Filed SEP 4 1923 ROBERT R. KRAUTER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/3 19 23

17 I HEREBY CERTIFY, That I attended deceased from ....., 19 ..... to 9/3 19 23

that I last saw her alive on 9/3 19 23

and that death occurred, on the date stated above, at 9:15 A. m.

The CAUSE OF DEATH* was as follows:

Central Nervous Lues

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. ds.

18 Where was disease contracted if not at place of death? U. S. Albany Georgia 1637 Carondelet

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edith H Dieudonné M. D.

19 (Address) 1013 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: Sept 5 1923

20 UNDERTAKER: Henry H Perkins Sons Co — ADDRESS: Eutaw & McCulloh Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78827 74-801 ✓ D78827

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 10 WARD)

2-FULL NAME John Suber

(a) RESIDENCE NO. 1303 Ashland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Suber

6 DATE OF BIRTH (month, day, and year) June 10, 1871

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 6, 1922, to Sept 2, 1923, that I last saw him alive on Sept. 2, 1923, and that death occurred, on the date stated above, at 4 45 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Hypertension

Right Hemiplegia (duration) 1½ yrs. (hrs.) mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude A. Draca M. D.

9-2, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem.	Sept. 5 1923
20 UNDERTAKER	ADDRESS
Mrs J. H. Locks	1302 Jeffers

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

KODAK S·A

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Apoplectic

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

16628! 113 ✓

CERTIFICATE OF DEATH.

D78828

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. 20

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Charles Kiefe

(a) RESIDENCE No. 30 Dolphin St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced, (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) Nov 20. 1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER Ernest Kiefe

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Smit

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant (Address) JOHNS HOPKINS HOSPITAL.

15 Filed ..... , 19 ..... Registrar

ROBERT N. KRAUTER, Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 31 , 1923, to Sept 3 , 1923, that I last saw h alive on Sept 3 , 1923, and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Diarrhoea (not dysentery)

(duration), yrs. 1½ mos ..... ds.

CONTRIBUTORY (Secondary) Peritonitis

..... (duration) yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Chas. R Bugg , M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet DATE OF BURIAL Sept 4/ 1923

UNDERTAKER AB Kilpatrick ADDRESS 15 E Fleet

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78829

D78829

CERTIFICATE OF DEATH.

49

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3910 Pk. Heights Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Seichting

(a) RESIDENCE No. 3910 Pk Heights Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 31 yrs. mos. ds.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Doretta Seichting

6 DATE OF BIRTH (month, day, and year): Jan 7 1833

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Wm. Seichting

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Eleanora Mechmans

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Wm. H Seichting 2611 N. Fairmount Ave

15 Filed SEP 4 1923 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 2. 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1922 to Sept 2 1923, that I last saw him alive on Sept 1 1923, and that death occurred, on the date stated above, at 1 40 A m.

The CAUSE OF DEATH* was as follows:

Epithelioma

(Cancer on Rt. Eyel

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Exhaustion - Feebleness.

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Visible growth.

(Signed) Milton P. Idell M. D.

19 (Address) Wyle ave. Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Pauls (Violetsville Md. DATE OF BURIAL: 9-4 1923

20 UNDERTAKER: Mrs Chas a G Rohde ADDRESS: 100 N Carlington

D78830

HEALTH DEPARTMENT—CITY OF BALTIMORE

700-001

D78830

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital St. ..... Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Edward Kistner

(Residence in Baltimore: No. 3405 Mt Pleasant Ave. St.; yrs.,.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	white	

6-DATE OF BIRTH. Nov. (Month) 14 (Day) 1922 (Year)

7-AGE, ... yrs. 9 mos. ..... ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Balto

PARENTS.

10-NAME OF FATHER, Edw Kistner

11-BIRTHPLACE OF FATHER, (State or Country), Balto

12-MAIDEN NAME OF MOTHER, Ida Haas

13-BIRTHPLACE OF MOTHER, (State or Country). Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edw Kistner

(Address) 3405 Mt Pleasant

15- Filed SEP4-1923 192 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH Sept (Month) 2 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) 4d auricular

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C Rodes M. D.

Sept 2 1923 (Coroner) (Address) 1436 E Bway

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Carmel Cem	Sept 1923

20-UNDERTAKER.	ADDRESS
John Welsh	2008 Orleans St

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC... is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78831 ✓ D78831

D78831

CERTIFICATE OF DEATH.

162

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 143 N Castle ST.: 6 WARD)

2-FULL NAME Gabriel Bowen

(a) RESIDENCE NO. 143 N Castle ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
			3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Alfred Bowen

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country)

12 MAIDEN NAME OF MOTHER Anna Otterbein

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Alfred Bowen
(Address) 143 N. Castle

15 Filed ..... 19 ..... Registrar

SEP 4 1923 ROBERT R. KRAUTER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Septmber 3 1923

17 I HEREBY CERTIFY, That I attended deceased from September 2. 1923. to September 3. 1923.

that I last saw h[illegible] alive on September 2. 1923.

and that death occurred, on the date stated above, at 330 A. m.

The CAUSE OF DEATH was as follows*:

Umbilical Hemorrhage

(duration) ..... yrs. ..... mos 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Exhaustion

(Signed) Albert Esquivel M. D.

9/3. 1923 (Address) 2027 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL Sept 4 1923

20 UNDERTAKER John Ulrich

ADDRESS 2008 Oakdale

Spec.—1-10-21—M&T—1500 Bks.

C-380934

D78832

HEALTH DEPARTMENT—CITY OF BALTIMORE

49

D78832

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U. S. Veterans' Hospital No. 56, Ft. McHenry REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W. BRIGHT

(a) RESIDENCE NO. 814 N. Howard St. Balto. Md., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Bright

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Window glass worker

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer unknown

9 BIRTHPLACE (city or town) Pa
(State or country) unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country) unknown

14 Informant Hospital Records
(Address) Ft. McHenry, Md.

15 Filed SEP 4 - 1923, 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4-23 19

17

I HEREBY CERTIFY, That I attended deceased from Aug. 14, 1923, to Sept. 4, 1923 19, that I last saw him alive on Sept. 4, 1923, 19, and that death occurred, on the date stated above, at 12.45 A. m.

The CAUSE OF DEATH* was as follows:

Cerabellar tumor

(duration) 2 yrs. 4 mos ds.

CONTRIBUTORY (Secondary)
Meningitis (duration) ... yrs. ... mos. 4 or 5

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? operated over one year ago

(Signed) Henry A. Smith, M. D.
Medical Officer in Temp. Charge
9-4- 19 23 (Address) Ft. McHenry, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Oakland, Md.

DATE OF BURIAL 9/7 1923

20 UNDERTAKER J. Thurston Bro

ADDRESS 127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Malignant

D78833

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-902
D78833

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1310 Small St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alice Rich

(Residence in Baltimore: No. 1310 Small St. St.; yrs. mos. 2 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
Female	colored	Single

6-DATE OF BIRTH. Sept. 2, 1923
(Month) (Day) (Year)

7-AGE. ....yrs. ....mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: comp
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Columbus Rich

11-BIRTHPLACE OF FATHER. (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Emma Jones

13-BIRTHPLACE OF MOTHER. (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Rich

(Address) 1310 Small St.

15- Filed Sept 4 1923 Robert P. Harrison, Registrar.
Deputy Registrar Clerk

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept. 4 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale

(Duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.
(Coroner.)

Sept 4 1923 (Address) 202 E Lanvale

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn	Sept 4 1923

20-UNDERTAKER.	ADDRESS
Sam'l E. Cassell	Woodlawn

THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78834

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78834

CERTIFICATE OF DEATH.

89

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 3024 Strickland ST. 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Koch

(a) RESIDENCE. No. 3024 Strickland ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? Unknown ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, ~~Widowed~~ or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary D. Koch

6 DATE OF BIRTH (month, day, and year): 1848

7 AGE: Years 75 Months 5 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cabinet Maker
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Potters 014

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS
10 NAME OF FATHER: Paul Koch
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): No Germany

14 Informant (Address): Mary Koch 3024 Strickland St

15 Filed SEP 4 - 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 2 1923

17 I HEREBY CERTIFY, That I attended deceased from 3/1/23 1923 to 9/2 1923
that I last saw h~~im~~ alive on 9/2 1923
and that death occurred, on the date stated above, at 4 m.
The CAUSE OF DEATH* was as follows:
Chronic nephritis with Uraemia poisoning
Congestion
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Angina pectoris
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3024 Strickland St
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Symptoms
(Signed) D. Damian P. Adorjan M.D.
, 19 (Address) 3326 Frederick Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park
DATE OF BURIAL: Sep. 5 1923
20 UNDERTAKER: C. W. Dill
ADDRESS 8109 Frederick Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78835

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 D78835

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Delila Jones

(a) RESIDENCE No. 2200 Oak St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't know

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 70

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Don't know

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Don't know

14 Informant Municipal Hospital Records
(Address)

15 Filed ..... 19 .....
Registrar

94 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1922, to Sept 3, 1923, that I last saw h.r alive on Sept 3, 1923 and that death occurred, on the date stated above, at 2.45 m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia (Terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude G. Howe, M. D.

9-4-1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 5 1923
20 UNDERTAKER Robt J Turner Inc	ADDRESS 1442 Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... SUPA-TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78836 129 D78836

D78836

CERTIFICATE OF DEATH.

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 W. 24 St ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophia E. Dennis.

(a) RESIDENCE. NO. 1206 W. 24 ST., ... WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female. | 4 COLOR OR RACE White. | 5 Single, Married, Widowed, or Divorced (write the word) Married.

5a If married, widowed, or divorced
HUSBAND of
WIFE of Wm. J. E. Dennis.

6 DATE OF BIRTH (month, day, and year) Dec. 21 - 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	8		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS
10 NAME OF FATHER Wm. A. Gray
11 BIRTHPLACE OF FATHER (city or town) (State or country)
12 MAIDEN NAME OF MOTHER Ellen Thazzer
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Wm J E Dennis
(Address) 1206 W 24th

15 Filed SEP 4-1923 . 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 26 1923, to Sept 3, 1923
that I last saw he alive on Sept 3, 1923
and that death occurred, on the date stated above, at 345 - m.
The CAUSE OF DEATH* was as follows:

Pneumonia.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) H. C. Williams M. D.
9/4/23 (Address) 2757 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 5 1923
20 UNDERTAKER Wm Cook	ADDRESS 502 E North

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78837

CERTIFICATE OF DEATH.

90 D78837

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin H & Calvert Sts. St.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fisher Mary Ui Tracy

(Residence in Baltimore: No. Franklin H & Calvert Sts St.; 31 yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Wht.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word) Single

6-DATE OF BIRTH, June (Month) 26 (Day), 1873 (Year)

7-AGE. 48 yrs. 2 mos. 9 da.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Seamstress 065
(b) General nature of industry, business, or establishment in which employed (or employer) House of Good Shepherd

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER. John Kettedt

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mother Superior

(Address) House of Good Shepherd

15- Robert P. Harrison,

Filed SEP 4 - 1923 1918 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. (Month) 4 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from April 1 1923, to Sept 9 1923, that I saw her alive on Sept 3 1923, and that death occurred, on the date stated above, at 5A. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Hypertrophy

(Duration) 5 yrs. mos. da.

CONTRIBUTORY (Secondary) Chronic Endocarditis

(Duration) yrs. mos. 20 da.

(Signed) J.S. Owens M. D.

9/4/23 191... (Address) 904 Cathedral St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Mt Cathedral

DATE OF BURIAL, Sept 6, 1923.

20-UNDERTAKER George L Schwartz

ADDRESS 1101 Eutaw Pl

CAUSE OF DEATH to be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D78838

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

15 1610 D78838

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1351 Gilmor ST.; 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant Rosella Tate

(a) RESIDENCE. No. 1351 Gilmor ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	negro	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	2½ hours/1923 Sept		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Jas H Tate

11 BIRTHPLACE OF FATHER (city or town) Washington D C
(State or country)

12 MAIDEN NAME OF MOTHER Mary Grant

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant
(Address)

15 Filed SEP 4-1923 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 19 23

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 19 23, to Sept 2, 19 23
that I last saw h.er alive on Sept 1, 19 23,
and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Premature Delivery
(6 month child)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm R Dorsey M. D.
. 19 (Address) 1618 Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
JOHNS HOPKINS HOSPITAL	
20 UNDERTAKER	ADDRESS

Filed SEP 4-1923 Wm. P. Harrison, Registrar
Clerk.
SEP 4-1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78839

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 D78839

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 9 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Sables

(a) RESIDENCE NO. 1504 N. Eden ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital
(Address)

15 Filed SEP 4 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 19, 1922, to Sept 1, 1923

that I last saw him alive on Sept 1, 1923

and that death occurred, on the date stated above, at 4.20 p.m.

The CAUSE OF DEATH* was as follows:

Sample Determination

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(Immediate) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude A Thomas, M. D.

9-4, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL ....., 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

Robert T. Carrigan,
Commissioner of Health.

SEP 4 1923

SEP 4 - 1923

Spec—12-23-21—E.B.R.S.—400 Blks.

D78840

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78840

CERTIFICATE OF DEATH.

Registered No. 6183

1-PLACE OF DEATH

City of BALTIMORE: (No. Municipal Tubercular Hospital 22 31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Stinger

(a) Residence No. 5 Lee St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, or Divorced. (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6-DATE OF BIRTH (month, day and year)

7-AGE: 35 ? yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Virginia

PARENTS.

10-NAME OF FATHER: John Stinger

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Va.

12-MAIDEN NAME OF MOTHER: Isabelle Johnson

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Va

14- (Informant)

(Address)

15- Filed ... 192 ... Registrar.

SEP 4-1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 8-31-23

17- I HEREBY CERTIFY, That I attended deceased from August 7 1923 to Aug. 31 1923

that I last saw him alive on Aug 31 1923

and that death occurred, on the date stated above, at 10.20 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Sputum & X-ray.

(Signed) L. A. Lakly M. D

19 (Address) Municipal T.B. Hosp.

*State the Disease Causing Death, or if deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: DATE OF BURIAL, 19

20-UNDERTAKER: ADDRESS

SEP 4-1923

Robert F. Garrison, Commissioner of Health

Ed. Exact statement of OCCUPATION is ve... impo... See instructions on back of certificates. In plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

D78841

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78841

101-001

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St. 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Brennan

(a) RESIDENCE NO. Bay View Asylum ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60 (?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ?

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records
(Address) UNIVERSITY OF MARYLAND.

15 Filed SEP 4 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 1 1923

17 I HEREBY CERTIFY, That I attended deceased from June 22, 1923 to Sept 1, 1923.

that I last saw him alive on Sept 1, 1923

and that death occurred, on the date stated above, at 4:15 P.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Senile Dementia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. X-ray

(Signed) Claude G Lowry, M. D.

9-4, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

SEP 4 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78842

CERTIFICATE OF DEATH.

57 D78842

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3305 Foster Ave. St.: 26 Ward)

2-FULL NAME Mary K. Dottenreich.

(a) RESIDENCE. No. 3305 Foster Ave. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? 51 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew Dottenreich.

6 DATE OF BIRTH (month, day, and year): July 29-1848

7 AGE: Years 75; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Adam Gebhardt.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Catherine Barker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Mrs. John Boehm (Daughter)

(Address) 3305 Foster Ave.

15 Filed SEP 4-1923, 19 Robert E. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 2 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug 13, 1923, to Sept 2, 1923, that I last saw her alive on Sept 1, 1923, and that death occurred, on the date stated above, at 10 A. M. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Carbuncle

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Harold B Tilson, M. D.

Sept 3, 1923 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cem. DATE OF BURIAL: Sept. 5 1923

20 UNDERTAKER: Lilly and Zeiler. ADDRESS: 1003 E. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78843

CERTIFICATE OF DEATH.

44 D78843

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mr. Henry Hagengast

(a) Residence No. Archbishops Residence St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1862

7-AGE. 61 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Priest

(b) General nature of industry, business, or establishment in which employed (or employer). R.C.

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Geo. Hagengast

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Bavarian

12-MAIDEN NAME OF MOTHER, Mary Koenig

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Bavaria

14- (Informant) Hospital Records.

(Address)

15- Filed ..... 192.....

Robert P. Harrison, Registrar.

SEP 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). Sept. 2-1923.

17- I HEREBY CERTIFY, That I attended deceased from 6/23/23, 19..... to 9/2/23, 19.....

that I last saw h. alive on 9/2/23, 19.....

and that death occurred, on the date stated above, at 9.40 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Port. Gastro

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. W. Bosley M. D.

, 19 (Address) Mercy

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cem. DATE OF BURIAL. Sept. 6, 1923

20-UNDERTAKER. Lilly & Zeiler ADDRESS 403 S. Wolfe St.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78844

CERTIFICATE OF DEATH

D78844

1-PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Fawcett & Greene St. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wyckoff

(a) RESIDENCE No. 1514 Hanselt St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Wyckoff

6 DATE OF BIRTH (month, day, and year) June 25-1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Abraham Wyckoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.J.

12 MAIDEN NAME OF MOTHER Rachel Hill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.J.

14 Informant Hosp Records.

(Address)

15 Filed , 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

P 4-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3 1923

17

I HEREBY CERTIFY, That I attended deceased from 8-30, 1923, to 9-3, 1923, that I last saw him alive on 9-3, 1923, and that death occurred, on the date stated above, at 3:40 A m.

The CAUSE OF DEATH* was as follows:

acute appendicitis with generalized peritonitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) acidosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 8-31-23

Was there an autopsy? No Clinical findings

What test confirmed diagnosis?

(Signed) B. Boyer M. D.

, 19 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
LOUDON PARK CEM	SEPT 5 1923
20 UNDERTAKER ROBT. BROOKS SON	ADDRESS CALHOUN HOLLINS ST

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78845

CERTIFICATE OF DEATH.

90 D78845

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1505 N. Washington St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mr Catherine A. Urner

(a) Residence No. 1505 N. Washington St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Urner

6-DATE OF BIRTH (month, day and year) June 15, 1840

7-AGE. 83 yrs. mos. ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER. Frank Kornhaas

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). do

14- (Informant). Joseph L. Urner

(Address) 2222 Kenneman Ave

15- Filed SEP 4-1923 192 Robert P. Harrison, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 2-1923

17- I HEREBY CERTIFY, That I attended deceased from Jan 1st 1923 to Sept 2nd 1923

that I last saw h. alive on Sept 1st 1923

and that death occurred, on the date stated above, at 2P m.

The CAUSE OF DEATH* was as follows:

Chronic Endo-Endocarditis

Unknown (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Jefferies Brack M. D.

9/3 1923 (Address) 2844 St Paul St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer Cem. DATE OF BURIAL. Sept. 5, 1923

20-UNDERTAKER. Geo. M. Fiss & Son ADDRESS 811 N. Wolfe St

Be sure to write plainly. Exact statement of OCCUPATION is very important. Answers must be in plain terms, so that it may be properly classified. Examine instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78846

CERTIFICATE OF DEATH.

54 001 D78846

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1965 Patterson Pl ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Mersmann

(a) RESIDENCE NO. 1965 Patterson Pl ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 9 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or ~~divorced~~ (or) WIFE of ~~HUSBAND of~~ Mersmann Charles Huttenbrugger

6 DATE OF BIRTH (month, day, and year) Nov 9 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home wife

(b) General nature of industry, business, or establishment in which employed (or employer) 237

(c) Name of employer

9 BIRTHPLACE (city or town) Bullo
(State or country) md

PARENTS

10 NAME OF FATHER Wm Huttenbrugger

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) city

12 MAIDEN NAME OF MOTHER Mary A O'Malley

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) city

14 Informant Mrs Edward Carlile
(Address) 1965 Patterson Place

15 Filed ..... 19 ..... Registrar

P4-1323

Robert P. Harrison.
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Sept 3, 1923, that I last saw h[illegible] alive on Sept 3 1923 and that death occurred, on the date stated above, at 8 50 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage Apoplexy

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Cardiac arthritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Albert H. Tracy M. D.

9/4/23 (Address) 1735 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Hampstead Rd

DATE OF BURIAL 9/7/1923

20 UNDERTAKER E. J Fanning & Son, 1938 E Lafayette

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78847

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78847

CERTIFICATE OF DEATH.

113

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 Cherry Ave. Rospebury ST., 26 WARD)

2-FULL NAME John Charles Roth

(a) RESIDENCE NO. 8 Cherry Ave. Rospebury ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 28th 1922

7 AGE — Years | 11 Months | 6 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Maryland

PARENTS

10 NAME OF FATHER Louis H. Roth

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lulu C. Detz

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Maryland

14 Informant Louis H. Roth (Address) 8 Cherry Ave. Rospebury

15 Filed SEP 4 1923 Robert P. Harrison Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 1923 to Sept 3 1923.

that I last saw him alive on Sept 3 1923.

and that death occurred, on the date stated above, at 6.55 P. m.

The CAUSE OF DEATH* was as follows:

Acute Colitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. E. Fischer M. D.

Sept 4 1923 (Address) 1301 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Sept. 6 1923

20 UNDERTAKER Fredk Lasseter & Son — ADDRESS Fullerton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

(Owings)

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78848

D78848

CERTIFICATE OF DEATH.

X 49

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. Mercy Hospital St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mrs Blanche Owens

(a) Residence No. Simpsonville Md St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1858

7-AGE. 65 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife 037

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER, John Watkins

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Malinda Linthicum

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) Hospital Records

(Address).....

15- Filed SEP 4-1923, 192.....

Robert P. Harrison, Registrar.

Deputy Health Officer.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/4/23

17- I HEREBY CERTIFY, That I attended deceased from 8/18/23, 19..... to 9/4/23, 19.....

that I last saw h alive on 9/4/23, 19.....

and that death occurred, on the date stated above, at 2.40 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Thyroid,

?

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? Radium applied. Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) K. W. Dolley M. D.

, 19 (Address)

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet DATE OF BURIAL. Sept 6, 1923

20-UNDERTAKER. Easton Sons ADDRESS Ellicott City

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78849

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78849

CERTIFICATE OF DEATH. X-165

Registered No. C.....

1-PLACE OF DEATH
City of BALTIMORE: (No. ..... Ridgewood Ave. & Western Maryland Railroad St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME ..... Robert M. Hook

(Residence in Baltimore: No. ... Los Angeles, California ..... St., yrs. ..... mos. 1 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced. (Write the word.)
Male	White	Single

6-DATE OF BIRTH. March (Month) 19 (Day) 1881 (Year)

7-AGE. 42 yrs. 5 mos. 15 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Clerical Work
(b) General nature of industry, business, or establishment in which employed (or employer) ..... Lumber Co.

9-BIRTHPLACE. (City or County) Glenwood, Howard Co. Md.

PARENTS.

10-NAME OF FATHER. Charles A. Hook.

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Co. Md.

12-MAIDEN NAME OF MOTHER. Louisa Warfield

13-BIRTHPLACE OF MOTHER, (State or Country). Howard Co. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Evan W. Hook
(Address) 210 Roland Rd. Roland Pk.

15-
Filed SEP 4 1923 192.....
Robert P. Harrison, Burial Permit Clerk.
Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. September (Month) 3 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paresis
(Drank Lysol)
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. T. Hennessy, M. D.
(Coroner)
9/4/23 192. (Address) 2802 Edmondson Ave.

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Glenwood Int	Sept 5 1923
20-UNDERTAKER.	ADDRESS.
Joseph B. Cook	1003 N. Balto St

Is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78850

CERTIFICATE OF DEATH.

90 D78850

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 928 N. Fulton Ave. 16 WARD)

2-FULL NAME Alfred O. Nielsen

(a) RESIDENCE NO. 928 N. Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie C. Nielsen

6 DATE OF BIRTH (month, day, and year) May 21. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ..min.
	57	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Agent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Copenhagen Denmark

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Nellie C. Nielsen

(Address) 928 N. Fulton Ave

15 Filed SEP 5 - 1923 19 ROBERT N. KARR Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1923

17

I HEREBY CERTIFY, That I attended deceased from July 14, 1923, to Sept 2, 1923, that I last saw him alive on Sept 2, 1923 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest D. Kahn M. D.

9/3, 1923 (Address) 910 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Sept 5 1923
20 UNDERTAKER	ADDRESS
H. Sander Sons	110 Fleet St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

D78851

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

D78851

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 606 W. Barre ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hezekiah B. Brown

(a) RESIDENCE NO. 606 W Barre ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. 10 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male | 4 COLOR OR RACE Col | 5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha Brown

6 DATE OF BIRTH (month, day, and year) Oct, 3, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	22	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wagon Driver

(b) General nature of Industry, business, or establishment in which employed (or employer) Chair Factory

(c) Name of employer Harrington & Cooper

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER William H Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Maryland

12 MAIDEN NAME OF MOTHER Mary M. Queen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant William H. Brown (Address) 606 W. Barre St

15 Filed SEP 5 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept, 3 1923

17 I HEREBY CERTIFY, That I attended deceased from July, 16, 1923, to Sept, 3, 1923, that I last saw h alive on Sept, 3, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. 1 mos 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum exam. pneumococci

(Signed) David Francken M. D.

9/4, 1923 (Address) 1200 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn | DATE OF BURIAL Sept 7 1923

20 UNDERTAKER John H. Toadvine | ADDRESS 142 N. Hill St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78852

CERTIFICATE OF DEATH.

001 D78852

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126 W Pleasant ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Fields

(a) RESIDENCE NO. 126 W Pleasant ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colord

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary Fields

(Address) 126 W. Pleasant St

15 Filed , 19 ROBERT R. KRAUTER, Registrar

SEP 5 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 3, 1923

17 I HEREBY CERTIFY, That I attended deceased from August 31. 1923. to September 3 1923.

that I last saw him alive on September 3. 1923.

and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

Bright Disease (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr Dillenwick M. D.

9-3. 1923 (Address) 708 Euson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sharpe Way Va.

DATE OF BURIAL: 9-5 1923

20 UNDERTAKER: David Easton

ADDRESS 916 Pa ne

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

12 D78853

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001 D78853

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3816 Green Mount ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Ida (Bryant)

(a) RESIDENCE NO. 3816 Green Mount ST., 12 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 6 mos. 11 ds. How long in U. S., if of foreign birth? 67 yrs. 6 mos. 11 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced. (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A. Bryant

6 DATE OF BIRTH (month, day, and year) Feby-23-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Geo. H. Smithill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Frank Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mr Raymond C. Bryant

(Address) 2610 Round-Q-Rd City.

15 Filed SEP 5 1923, 19 ROBERT R. KRAUER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3, 1923

17 I HEREBY CERTIFY That I attended deceased from Augt 31, 1923, to Sept 3rd, 1923, that I last saw her alive on Sept 3rd, 1923, and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 0 yrs. 0 mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of. — —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. Wyncoop M. D.

Sept 5, 1923 (Address) 1327 Park Ave, Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL Sept 5 1923

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN) — ADDRESS 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. I... TION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78854

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D78854

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2403 Christian ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME August Zoltz

(a) RESIDENCE NO. 2403 Christian ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Zoltz

6 DATE OF BIRTH (month, day, and year) Jan 20. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	73.	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Maker.

(b) General nature of industry, business, or establishment in which employed (or employer) Ret

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Mrs Augusta King (Address) 2403 E. Christian St.

15 Filed SEP 5 - 1923 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Sept 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Dec 19 [illegible] last two years.

that I last saw him alive on Sept 3 1923

and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis 1

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uremic Coma 4 days

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theodore Muldenny M. D.

Sept 4 1923 (Address) N 19 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park.	9/6. 1923.
20 UNDERTAKER J. Frew McCully.	ADDRESS 120 E Fort Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1J0-21—M&T—1500 Bks.

D78855

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D78855

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1100 William St ST., 24 WARD)

2-FULL NAME Charles L Schmidt

(a) RESIDENCE NO. 1100 William St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? 73 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Helena Schmidt

6 DATE OF BIRTH (month, day, and year) Mar 15 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	75	5	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Christian Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Benigna E Gotlieb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Schmidt
(Address) 209 East Cross St

15 Filed ..... 19 ..... Registrar

ROBERT N. KRANTZ
SEP 5 1923
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 2nd, 1923 to Sept 3rd, 1923, that I last saw him alive on Sept 3rd, 1923, and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis.

(duration) Several yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? /

(Signed) D D Simpson M. D.

9/4/1923 (Address) 301 East Cross St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	9/6/23
20 UNDERTAKER	ADDRESS
J. Tew McCully.	128 E Ford av.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Oneff

D78856

HEALTH DEPARTMENT—CITY OF BALTIMORE

4 D78856

CERTIFICATE OF DEATH.

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 509 N. Wolfe ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sharon Durrff

(a) RESIDENCE NO. 509 N. Wolfe ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Tailor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Nephew 1439 E. Baltimore

15 Filed SEP 5 1923, 19 ROBERT R. KRAUTH Burial Permit Clerk Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sep. 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15 1923, to Sep. 4, 1923

that I last saw him alive on Sep. 4, 1923

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Hugh Bayne M. D.

9/11, 1923 (Address) 710 Linwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Return Rosedale — DATE OF BURIAL Sept. 5th 1923

20 UNDERTAKER Fort Lewis, 1439 E. Balto. — ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78857

CERTIFICATE OF DEATH.

69 ✓ D78857

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1730 Chilton ST., 9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine E. Surendorf

(a) RESIDENCE NO. 1730 Chilton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 7 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 11th 22

7 AGE: Years 1 | Months 7 | Days 23 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Gustav Surendorf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. City

12 MAIDEN NAME OF MOTHER Kathyrine Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. City

14 Informant Gustav Surendorf

(Address) 1730 Chilton St.

15 Filed SEP 5 - 1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from August 18th, 1923, to Sept 3rd, 1923, that I last saw her alive on Sept 2nd at 12 M, 1923, and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Toxic or Septic Condition of Blood (Colon Bacillus) with Bronchopneumonia

(duration) yrs. mos 3 d.

CONTRIBUTORY (Secondary) Heart Hemorrhage

(duration) yrs. mos. 4 d.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) Calvin Smith, M. D.

, 19 (Address) S.W. Cor. Calvert & Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. DATE OF BURIAL: Sept. 5th 1923

20 UNDERTAKER: Philip Herwig ADDRESS 2016 Orleans St.

MATION should be clearly supplied. AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78858

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D78858

1-PLACE OF DEATH

City of BALTIMORE: (No. 2708 Keiserstown Road St., 15 Ward)

Registered No. C.....

2-FULL NAME Ford Frazier

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(Residence in Baltimore: No. 2509 Rockrose ave St.; yrs..... mos..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: M.

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word.): Widower

6-DATE OF BIRTH: August 1 1863
(Month) (Day) (Year)

7-AGE: 59 yrs. mos. ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE. (State or Country): Richmond Va

PARENTS.

10-NAME OF FATHER: Unknown

11-BIRTHPLACE OF FATHER, (State or Country): Unknown

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER, (State or Country): Unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marshall Frazier

(Address) 1422 Orleans St Balto Md

15-

Filed SEP 5 1923 ROBERT R. KRAUTER Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH: Sept 2 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries received from Elevated railroad train Accidental

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) Jno. J. Morrissey M.D.
(Coroner.)

192 3 (Address) 3492 Roland ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL: Washington DC DATE OF BURIAL: 9/5/23

20-UNDERTAKER: W. J. Tickner & Son ADDRESS: Park Ave

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

D78859

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D78859

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 564 Orchard St. St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Theodore Chase

(Residence in Baltimore: No. 564 Orchard St. St.; yrs., 2 mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	colored	Single

6-DATE OF BIRTH, June 17, 1921
(Month) (Day) (Year)

7-AGE, 1 yrs. 2 mos. 18 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore, Md.

PARENTS.

10-NAME OF FATHER, Herman Griffin

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Edith Chase

13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edith Chase

(Address) 564 Orchard St.

15- SEP 5 1923 ROBERT R. KRAUTER
Filed ..... 192.. Registrar.
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 3 192 3
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inq
(Inquest, autopsy or inquiry.) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration)..... yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) ..... no history

(Duration)..... yrs. mos. ds.

(Signed) ..... M. D.
(Coroner.)

Sept 4, 192 (Address) 2 E Fayette Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Mt Auburn	Sept 5 19 23

20-UNDERTAKER.	ADDRESS
Dud Taylor	5a 46

state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E FAYETTE ST

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78860

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78860

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2603 Keyser ST.: 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice M. Pembroke

(a) RESIDENCE. No. 2603 Keyser ST., 8 WARD.
(Usual place of abode)
(If nonresident give city or town and State)

Length of residence in city or town where death occurred Quite mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (or) WIFE of Thomas Pembroke

6 DATE OF BIRTH (month, day, and year) Dec 1 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	76	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Leonardtown St Marys Co Md

PARENTS

10 NAME OF FATHER John H Tudor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co Md.

12 MAIDEN NAME OF MOTHER Alice Underwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys Co Md

14 Informant Mrs Lucy Boone
(Address) 2603 Keyser Av

15 Filed SEP 5 - 1923 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 23

17 I HEREBY CERTIFY, That I attended deceased from Aug 6, 1923, to Sept 4, 1923, that I last saw her alive on Sept 4, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cystitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) B O Kenzo M D M. D.

Sept 6 1923 (Address) 1305 N Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ridge Md St Mary's County	Sept 5 1923
20 UNDERTAKER Henry Lutz	ADDRESS 1203 N. Broadway

INSTRUCTIONS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

DAAK KO

Spec.—1-10-21—M&T—1500 Blks.

D78861

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

162 D78861

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Md. Gen Hospt ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Divin

(a) RESIDENCE NO. 1922 Walbrook Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 4 min.
	✓	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Paul Clifford Divin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Maynette Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Michaels Md

14 Informant Mother.
(Address) 1922 Walbrook Ave

15 Filed ... , 19 ... ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 8-31-23

17

I HEREBY CERTIFY, That I attended deceased from 8-31-23 19 , to 8-31-23 19 ,

that I last saw h alive on 8-15-23 , 19 ,

and that death occurred, on the date stated above, at 3-29 a.m.

The CAUSE OF DEATH* was as follows:

Bronchial Infection

(duration) yrs. mos ✓ ds.

CONTRIBUTORY (Secondary) Asphyxia

(duration) yrs. mos. ✓ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? ✓

What test confirmed diagnosis? Clynical Symptoms

(Signed) no atomptsies, M. D.

, 19 (Address) Md Gen Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cremated. Hospital.	19
20 UNDERTAKER	ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78862

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D78862

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William R. Simpson

(a) RESIDENCE. No. 1324 N Chester ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 11, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER William R. Simpson

11 BIRTHPLACE OF FATHER (city or town) Lancaster
(State or country) Penna.

12 MAIDEN NAME OF MOTHER Anna M Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md

14 Informant Mt Hope Retreat
(Address)

15 Filed SEP 5 1923, 19... ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1923

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1923, to Sept 4, 1923, that I last saw h[illegible] alive on Sept 4, 1923, and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
(acute Cardiac Dilitation)

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis & Bladder Retention (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Hill, M. D.

, 19 (Address) Wyliss & Redwood Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Sept 5 1923
20 UNDERTAKER Gorsuch & Gorsuch	ADDRESS 1739 Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

Laur.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78863

CERTIFICATE OF DEATH.

44 D78863

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1012 N Monroe (St.) 16 (Ward)

2-FULL NAME Dr. Geo. Joseph Laur

(a) RESIDENCE: No. 1012 N. Monroe St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married.

5a If married, widowed, or divorced HUSBAND of [illegible]: Laur.

6 DATE OF BIRTH (month, day, and year): Nov 15, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Druggist.

(b) General nature of industry, business, or establishment in which employed (or employer): Retail Drug Store

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: George Laur

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Auer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Chas Laur 1012 N. Monroe St.

15 Filed SEP 5 - 1923, 19.... ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1923 to Sept 3, 1923, that I last saw him alive on Sept 2, 1923, and that death occurred, on the date stated above, at 10 9. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver.

(duration) yrs. mos. 27 ds.

CONTRIBUTORY (Secondary) Sarcoma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination & Exam. of Blood & Urine

(Signed) H. C. Baldwin, M. D.

9/7/23 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Sept 5. 1923

20 UNDERTAKER: H. C. Brauning & Sons — ADDRESS: 517 N. Howard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓

D78864

CERTIFICATE OF DEATH.

D78864

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 Baker ST.: 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Miller.

(a) RESIDENCE. No. 624 Baker ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. X mos. X ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Miller

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	X	X	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) $2.1

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Hodson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Andrew Holland (Address) 1027 Calhoun St

15 Filed . 19 Registrar

SEP 5 1923 ROBERT R. KRAUSE BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3- 1923

17 I HEREBY CERTIFY, That I attended deceased from August 26, 1923, to September 3, 1923, that I last saw her alive on September 1, 1923, and that death occurred, on the date stated above, at 4.45A m.

The CAUSE OF DEATH* was as follows:

C. Nephritis (duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) of Chronic valvular disease (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical Signs, Symptoms

(Signed) John E. Lampert M. D.

. 19 (Address) 1405 N. Mount.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	9/6 1923

20 UNDERTAKER Jas. H. Daniels ADDRESS 1303

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D78865

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

D78865

CERTIFICATE OF DEATH.

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ryland Fisher

(a) Residence No. 625 N. Mount St. St., Ward.....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. colored.

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) 1885

7-AGE. 38 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer 040

(c) Name of employer.....

9-BIRTHPLACE (city or town) Va. (State or Country).

PARENTS.

10-NAME OF FATHER. Henry Fisher.

11-BIRTHPLACE OF FATHER (city or town) Va. (State or Country).

12-MAIDEN NAME OF MOTHER. Lucinda Brodnax

13-BIRTHPLACE OF MOTHER (city or town) Va (State or Country).

14- (Informant) Hospital Records

(Address).....

15- Filed SEP 5 1923 ROBERT R. KRAUTER, Burial Permit Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 9/4/23

17- I HEREBY CERTIFY, That I attended deceased from 8/30/23 19.. to 9/4/23 19.. that I last saw h[illegible]live on 9/4/23 19.. and that death occurred, on the date stated above, at 12.20 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. W. Gelbey M. D.

, 19 (Address) Mercy

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn — DATE OF BURIAL. 9/6 19 23

20-UNDERTAKER. Jno H. Dennis — ADDRESS, 203 Fremont St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78866

CERTIFICATE OF DEATH.

89 D78866

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1923 N Fayette ST.; 20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John. Lemmerman

(a) RESIDENCE. NO. 1923 N Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary E Lemmerman

6 DATE OF BIRTH (month, day, and year) Aug 10 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	0	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Tool Dresser
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John D Lemmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Hafter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant (Address) Mary E Lemmerman. 1923 N Fayette St

15 Filed SEP 5 1923 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2nd 1923

17 I HEREBY CERTIFY, That I attended deceased from May 28th, 1923 to Sept 2nd, 1923.

that I last saw him alive on September 1st, 1923.

and that death occurred, on the date stated above, at 10:45 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 3 mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 1 year yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Henry C. Dilke, M. D.

9/6 1923 (Address) 1207 N. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	9-5 1923

20 UNDERTAKER Mrs Chas A G Rohde ADDRESS 600 n Arlington Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78867

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002

D78867

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. St Joseph's Hospital. ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary G. Kercher.

(a) RESIDENCE NO. 2815 E. Monument ST., 7th WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married.

5a If married, widowed, or divorced (or) WIFE of J. Ferdinand Kercher

6 DATE OF BIRTH (month, day, and year) Sept. 21 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer) 137

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Patrick Mullahey

11 BIRTHPLACE OF FATHER (city or town) Ireland (State or country)

12 MAIDEN NAME OF MOTHER Mary A. Colleran

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant J. Ferdinand Kercher (Address) 2815 E Monument St

15 Filed SEP 5 - 1923 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9- 3- 1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept. 4 1923; to Sept. 6 1923; that I last saw h alive on Sept. 5 1923; and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 8 da.

CONTRIBUTORY (Secondary) Intestinal Obstruction -

(duration) yrs. mos. 3. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes. Date of Sept. 4-1923.

Was there an autopsy? Yes.

What test confirmed diagnosis? P.S.+S. and Operation

(Signed) Harold C Pallatory M. D.

, 19 (Address) St Joseph's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL Sept. 8 1923

20 UNDERTAKER Henry Hoeck Son ADDRESS 1301 E Eager

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D78868

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78868

CERTIFICATE OF DEATH.

139

1-PLACE OF DEATH — Registered No.....

City of BALTIMORE: (No. 408 S Pulaski St., 21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Eva L Grimes

(a) Residence No..... 408 S Pulaski St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 74 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of James L Grimes

6-DATE OF BIRTH (month, day and year) May 23 1849

7-AGE, 74 yrs. 3 mos. ... ds. If LESS than 1 day, ... hrs. or ... min.*

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Md

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Md

14- (Informant) James L Grimes
(Address) 408 S Pulaski St

15- Filed ... 19... Registrar.

SEP 5-1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 4 23

17- I HEREBY CERTIFY, That I attended deceased from February 1, 1915, to Sept 4, 1923, that I last saw h. alive on Aug. 30, 1923, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) 10 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Edema Dumm of Uterus

(Duration) 15 yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J M Dilcutt M. D.

Sept 5, 1923 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill — DATE OF BURIAL: Sept 6, 1923

20-UNDERTAKER: William Cahoon & Nathan — ADDRESS

In plain words, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D78869

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78869

CERTIFICATE OF DEATH.

182

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Pier 6 Pratt St., ST., WARD)

2-FULL NAME Pelman Cheeks

(a) RESIDENCE NO. 1646 Stockton St. ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
about 20	[illegible]	[illegible]	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Deckhand
(b) General nature of industry, business, or establishment in which employed (or employer) Boat
(c) Name of employer [illegible]

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant.....
(Address)

15 Filed SEP 5 - 1923 192 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug 29 192 23

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidentally drowned
in jumping from boat to
Wharf. Sudden
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible], M. D.
(Coroner.)

Sept 3 192 3 (Address) 705 Penn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY. DATE OF BURIAL SEP 5 - 1923 192

20 UNDERTAKER [illegible] ADDRESS [illegible]

Robert P. Harrison,
PUBLIC MORGUE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU-PATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D78870 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D78870

CERTIFICATE OF DEATH.

1-PLACE OF DEATH — Registered No. 6105

City of BALTIMORE: (No. Municipal Tubercular Hospital 26 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Richard Von Bergen

(a) Residence No. 63rd and Biddle St. St., Ward.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced (Write the word.)
Male	White	Widowed

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Widowed

6-DATE OF BIRTH (month, day and year)

7-AGE	If LESS than 1 day
35 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): New Jersey

PARENTS.

10-NAME OF FATHER: Richard Von Bergen

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Germany

12-MAIDEN NAME OF MOTHER: Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Germany

14-
(Informant): Patient
(Address): 63rd and Biddle St.

15-
Filed 1923 192 Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 9-2-23

17- I HEREBY CERTIFY, That I attended deceased from May 1, 1923 to Sept 2, 1923, that I last saw him alive on Sept 2, 1923, and that death occurred, on the date stated above, at 4.20 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 8 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(Duration) yrs. 10 mos. ds.

18-Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum & X-ray

(Signed) L. C. Lasby M. D.

, 19 (Address) Municipal TB Hosp

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. SEP 5 - 1923 19

20-UNDERTAKER, Commissioner of Health. ADDRESS

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

UNIVERSITY OF MARYLAND

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78871 ✓ 90 D78871

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME David Collins

(a) RESIDENCE NO. B. V. A ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) New York
(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed ....., 19.... Registrar

SEP 5 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 2 1923

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1923, to Sept 2, 1923

that I last saw h alive on Sept 2, 1923

and that death occurred, on the date stated above, at 4:20 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (Degenerative)

Auricular Fibrillation

Myocardial Insufficiency

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude G. Brace, M. D.

9-5, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Commissioner of Health. SEP 5 - 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND
Alice P. Harrison
HOSPITAL Permit Clerk.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78872

CERTIFICATE OF DEATH.

161-00 D78872

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 215 So. Castle ST., 2 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Firnstein

(a) RESIDENCE NO 215 So. Castle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 4th/23

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	one	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Philipp Firnstein

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Florence Blasing

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Philipp Firnstein
(Address) 215 So Castle St

15 Filed SEP 5 1923 Robert P. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4th 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B. Horton M. D.
(Coroner.)

Sept 5 1923 (Address) Curtis Bay Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Redeemer Cem

DATE OF BURIAL Sept 5 1923

20 UNDERTAKER Lilly & Feiler

ADDRESS 403 Broadway

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78873

CERTIFICATE OF DEATH.

57 ✓ D78873

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 30 Altona Ave ST.: 27 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline J. Mann

(a) RESIDENCE. No. 30 Altona Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 10 mos. 24 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry E. Mann

6 DATE OF BIRTH (month, day, and year) Oct. 10, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Johann C. Storch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frankfort Germany

12 MAIDEN NAME OF MOTHER: Caroline A. Wild

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Florence M. Mann 30 Altona Ave. Hamilton

15 Filed SEP 5 1923, 19.. Robert F. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1923

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1923 to Sept 3, 1923

that I last saw h er alive on Sept 3, 1923

and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine, Sugar

(Signed) Henry Lowy M. D.

(Address) 27 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	9/6 1923
20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78874

CERTIFICATE OF DEATH.

49 D78874

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 W. Lexington ST. 18 WARD)

2-FULL NAME Clara M. Schroder

(a) RESIDENCE NO. 811 W. Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 10 mos. 27 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 ~~Single, Married, Widowed, or Divorced~~ (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Richard F. Schroder

6 DATE OF BIRTH (month, day, and year): Oct 8 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John W. Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Georgana Russell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Richard F. Schroder
(Address) 811 W. Lexington St

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 1923, to Sept 3, 1923, that I last saw h[illegible] alive on Sept 3, 1923, and that death occurred, on the date stated above, at 10 [illegible] m.

The CAUSE OF DEATH* was as follows:

c Carcinoma Bladder

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

9/4/23 (Signed) E Hellen Hemmig, M. D.

(Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Sept 6 1923
20 UNDERTAKER	ADDRESS
Jos Jourdans Son	2078 Pa

SEP 5 1923 Robert P. Barrison, Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78875

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78875

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 Harlem Ave ST., 17 WARD)

2-FULL NAME Mrs. Virginia Eloise Gumby.

(a) RESIDENCE NO. 811 Harlem Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL - PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Wm C. C Gumby.

6 DATE OF BIRTH (month, day, and year) July 31-1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	Seventy	One	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER George W. C. Neal.

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Miss L Johnston

13 BIRTHPLACE OF MOTHER (city or town) Charleston (State or country) South Carolina

14 Informant Mrs Grace A Mullikin

(Address) 1401 W Lanvale St.

15 Filed ..... 19 ..... Registrar

Robert P. Harrison

Burial Permit Clerk

P5-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3rd 1923

17 I HEREBY CERTIFY, That I attended deceased from November 15 1922. to Sept 8th 1923.

that I last saw her alive on Sept 3rd 1923.

and that death occurred, on the date stated above, at 8-20 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Disease (Valvular)

(duration) 1½ yrs. mos da.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings.

(Signed) J Bonnell Fouge, M. D.

. 19 (Address) 2937 W Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. — DATE OF BURIAL: Sept 6 1923

20 UNDERTAKER: Jos Joerdens Son — ADDRESS: 217 S Pac

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78876

CERTIFICATE OF DEATH.

74-001 D78876

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1107 Valley St. ST., 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose L. Sturgeon (nee Mooney)

(a) RESIDENCE NO. 1107 Valley St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 5 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. L. Sturgeon

6 DATE OF BIRTH (month, day, and year) Jan 29. 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	61	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 637

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Thomas W. Mooney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine E. Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto City

14 Informant Rose L. Sturgeon (Address) 1107 Valley St

15 Filed SEP 6 1923 19 ROBERT R. KRAUTER Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5th 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 2 1923. to Sept. 5 1923.

that I last saw her alive on Sept. 4 1923

and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Apoplexy (hemorrhage) first eight months age 6

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) S. Patrogenes, M. D.

9-5 1923 (Address) 1206 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Sept 8th 1923
20 UNDERTAKER H. C. Wiedefeld	ADDRESS 914 Fremont Ave

MEDICAL CERTIFICATE OF DEATH should be carefully supplied. Exact statement of OCCUPATION should be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates. CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78877

CERTIFICATE OF DEATH.

161-001 D78877

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hosp. ST., 70 WARD)

2-FULL NAME Baby Girl Finley

(a) RESIDENCE NO. 4005 E. Edmondson Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or 50 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St Agnes Hosp. Baltimore Md.

PARENTS

10 NAME OF FATHER: Joseph Finley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Joseph Finley
(Address) 4005 - Edmondson Ave

15 Filed ..... 19..... ROBERT A. KRAUTER Registrar

SEP 5 1923 BUREAU OF VITAL STATISTICS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 5 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1923, to Sept 5, 1923, that I last saw h[illegible] alive on Sept 5 - 1923, and that death occurred, on the date stated above, at 8 50 a m.

The CAUSE OF DEATH* was as follows:

Premature delivery

due to Malformation

Dependent upon - Operation

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Fernando N. Nicholas, M. D.

, 19 (Address) 906 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: 9/6/23

20 UNDERTAKER: H. C. Wedefeld 914 Fremont

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Vernnce

D78878

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-002

D78878

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 410 Glenedward Ave ST. 13 WARD)

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Vernnce

(Residence in Baltimore: No. 410 Glenedward Ave St.; yrs., mos. da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Sept 4, 1923
(Month) (Day) (Year)

7-AGE, ...yrs...mos...da.

If LESS than 1 day, 9 hrs. or ...min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Balto. City

PARENTS.

10-NAME OF FATHER, John Vernnce

11-BIRTHPLACE OF FATHER (State or Country), Italy

12-MAIDEN NAME OF MOTHER, Rosella DeJanuta

13-BIRTHPLACE OF MOTHER (State or Country), Italy

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Vernnce

(Address) 410 Glenedward Ave

15-

Filed ..., 191.

SEP 6 1923 ROBERT R. KRAUTER, Burial Permit Clerk Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 5, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inq (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hem. X. Disease

(Duration) ...yrs. ...mos. ...da.

CONTRIBUTORY (Secondary) ...

(Duration) ...yrs. ...mos. ...da.

(Signed) John J. Morrissey M. D.
(Coroner)

Sept 5, 191 (Address) 3632 Roland Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...da. In the State ...yrs. ...mos. ...da.

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19-PLACE OF BURIAL OR REMOVAL, St Vincent DATE OF BURIAL, Sept 9 1923

20-UNDERTAKER, A L Marshall ADDRESS 2539 Fall Rd

CAUSE OF DEATH to be plainly stated, so that it may be properly classified. EACH statement OF OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-23 M&T 1500 Blks.

D78879

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 ✓ D78879

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1205 Whatcoat ST., 16 WARD)

2-FULL NAME Madison Simpson

(a) RESIDENCE NO. 1205 Whatcoat ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Louisa Simpson

6 DATE OF BIRTH (month, day, and year) Aug 15-1895

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	28		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER John Simpson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elyate Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Louisa Simpson (Address) 1205 Whatcoat

15 Filed SEP 6 1923, 19.. ROBERT R. KRAMER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/5- 1923

17

I HEREBY CERTIFY, That I attended deceased from 7/6 1923, to 9/5- 1923.

that I last saw h~ alive on 9/5- 1923,

and that death occurred, on the date stated above, at 8A m.

The CAUSE OF DEATH* was as follows:

Pulthysis Pulmonalis

(duration) yrs. 2 mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H Burkett, M. D.

9/6, 1923 (Address) 2154 Dix a

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
West Point Va	Sept 7 1923
20 UNDERTAKER Sam'l W. Chase Hse	ADDRESS 1400 Madison

Spec.—1-10 21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78880 — 1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 640 Smith — ST., 14 WARD)

2-FULL NAME Wm Lee

(a) RESIDENCE NO. 640 Smith — ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

1919 D78880 REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Rebecca Lee

6 DATE OF BIRTH (month, day, and year) Sept 10, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Columbia
(State or country) Penna

PARENTS

10 NAME OF FATHER Samuel Lee

11 BIRTHPLACE OF FATHER (city or town) Columbia
(State or country) Penna

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Columbia
(State or country) Penna

14 Informant May Lee
(Address) 733 School St

15 Filed SEP 6. 1923 ROBERT N. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3. 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 24th, 1923, to Sept 3rd, 1923, that I last saw h[illegible] alive on Sept 3rd, 1923 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

(a) Chronic Nephritis
Chronic

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Stomach trouble

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) A. Lee Thos, M. D.

9/4, 1923 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Grove Cem — DATE OF BURIAL 9-6-1923

20 UNDERTAKER Harold Easton. — ADDRESS 916 Pa ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D78881

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78881

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hospital ....St., 4 .....Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... Leon T. Dunaway .....

(Residence in Baltimore: No. 619 W. Mulberry St. .....St.; yrs.....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, Divorced. (Write the word.)
male	black	single

6-DATE OF BIRTH. Oct 9/22 , 1.....
(Month) (Day) (Year)

7-AGE. .....yrs. 10 mos. 25 ds. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE. (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Walter Dunaway

11-BIRTHPLACE OF FATHER. (State or Country). Va.

12-MAIDEN NAME OF MOTHER. Elizabeth Berrie

13-BIRTHPLACE OF MOTHER. (State or Country). Washington D.C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elizabeth Dunaway

(Address) 619 W. Mulberry St.

15- Filed SEP 6 1923 ROBERT R. KRAUTER, Burial Permit Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 4/23 , 192.....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said.....
(Inquest, autopsy or inquiry.)
find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Indigestion

(Autopsy at Hospital)

(Duration).....yrs.....mos.....ds.

CONTRIBUTORY.....
(Secondary)

(Duration).....yrs.....mos.....ds.

(Signed) J. H. Collins M. D.
(Coroner.)

9/5/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cem	9-6 1923
20-UNDERTAKER, Wm. O'Connor	ADDRESS 916 E Fayette

Is very important. See instructions on back of certificate. STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78882

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 D78882

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 S. Payson ST.: 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George John Miller

(a) RESIDENCE. NO. 415 S. Payson ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) July 27-1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinner

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Henry Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Agnes Lauck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Edna Hoffman

(Address) 415 S. Payson

15 Filed SEP 6 1923 ROBERT A. KRAULER, Burial Permit Clerk. 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov 7, 1922, to Sept 2, 1923

that I last saw him alive on Sept 2, 1923

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

Cardiac

..... (duration) 1½ yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical & X Ray

(Signed) E. Hellen Hemming, M. D.

9/4, 1923 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Sept 6th 1923
20 UNDERTAKER	ADDRESS
Geo. Weber & Son	2503 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78883 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ D78883

90

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sheffield Apts 13 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Meyer Fox

(a) RESIDENCE NO. Sheffield Apts ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Esther Koopman Fox

6 DATE OF BIRTH (month, day, and year) May 22, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Transfer Business

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Moses Fox

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Germany

12 MAIDEN NAME OF MOTHER Roda Neuberger

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Germany

14 Informant Mr. Louis Fox (Address) Pk. Heights Ave

15 Filed SEP 6 - 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/6/ 1923.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1907, to present time 1923, that I last saw him alive on Sept. 5, 1923, and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 20 yrs. mos ds.

CONTRIBUTORY (Secondary) Angina Pectoris

10 (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Urine, Blood Pressure

(Signed) Dade R. Pels, M. D.

, 19 (Address) 1011 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	9/7 1923
20 UNDERTAKER David Sondheim	ADDRESS 118 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78884

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D78884

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 E. 20th ST., 9 WARD)

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Grace Coyle

(a) RESIDENCE No. 512 E. 20th ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Coyle

6 DATE OF BIRTH (month, day, and year) Aug 22-1875

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
48	—	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Chas E. Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie McGill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John F. Coyle
(Address) 512 E. 20th St.

15 Filed ..... 19 .....

SEP 8 1923

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1923

17 I HEREBY CERTIFY, That I attended deceased from June 3rd 1923, to Sept 4th 1923

that I last saw h alive on Sept 4th 1923

and that death occurred, on the date stated above, at 1. a m.

The CAUSE OF DEATH* was as follows:

Endocarditis. Mitral Insufficiency

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) yrs. 4 mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. R. Saunders, M. D.

, 19 (Address) 219 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 9/8 1923

UNDERTAKER Chas F. Evans & Son — ADDRESS 118 W. Mt Royal ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78885

HEALTH DEPARTMENT—CITY OF BALTIMORE.

101-001

D78885

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST.: 38 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Maloney

(a) RESIDENCE. No. Hollidaysburg, Pa. ST., 38 WARD. Hollidaysburg Pa

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ? ds. How long in U. S., if of foreign birth? 59 yrs. 1 mos. 24 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) August-2-1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 073

(b) General nature of industry, business, or establishment in which employed (or employer) Retired P.R.R.

(c) Name of employer Office Philadelphia Pa

9 BIRTHPLACE (city or town) (State or country) John Maloney Coalree Ireland

PARENTS

10 NAME OF FATHER John Maloney

11 BIRTHPLACE OF FATHER (city or town) Coalree (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Hoyes

13 BIRTHPLACE OF MOTHER (city or town) Tynebeck (State or country) Ireland

14 Informant Mt Hope Friends (Address)

15 Filed SEP 6 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1923

17 I HEREBY CERTIFY, That I attended deceased from July 28 1923, to Sept 6, 1923, that I last saw him alive on Sept 5, 1923, and that death occurred, on the date stated above, at 3.30 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Depressor Mania)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at Place of work

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Milton P. Hall, M. D.

, 19 (Address) Hospital Hollidaysburg Pa

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hollidaysburg-Penna	Sept 6 1923
20 UNDERTAKER STEWART & MOORE [illegible]	ADDRESS 100 W. [illegible] AVE

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78886

CERTIFICATE OF DEATH.

129 D78886

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 E. Preston St ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Farnandis Mitchell

(a) RESIDENCE NO. 112 E. Preston St ST., 11 WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 49 yrs. 11 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter, R. Mitchell

6 DATE OF BIRTH (month, day, and year) Oct. 1-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Bel-Air Harford Co. Md

PARENTS

10 NAME OF FATHER Richard H. Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co Md.

12 MAIDEN NAME OF MOTHER Elizabeth Farnandis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bel-Air Harford Co. Md.

14 Informant Walter. R. Mitchell (Husband)
(Address) 112 E. Preston St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-4 1923

17 I HEREBY CERTIFY, That I attended deceased from July 7, 1923, to Sept 4, 1923.

That I last saw her alive on Sept 4 1923

and that death occurred, on the date stated above, at 4 p. m.

The CAUSE OF DEATH* was as follows:

Anemia

CONTRIBUTORY (Secondary) Hysterius (duration) Chronic yrs. Parenchymatous over 2 mos. 3 ds. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Laboratory Chemical test

(Signed) Wm B Magee M. D.

(Address) Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Sept. 6/23

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. WOODEL)

ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

SEP 6 1923 ROBERT B. KRAMER Registrar of Vital Records

Spec.—6-9-19—H. P. Co.—1000 Bks.

Babel

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78887

CERTIFICATE OF DEATH.

129 D78887

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1157 N. Calhoun ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan E. Herbert

(a) RESIDENCE. No. 1157 N. Calhoun ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William H. Herbert

6 DATE OF BIRTH (month, day, and year): Feb 22 1838

7 AGE: Years 85 Months 7 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Co Md

PARENTS

10 NAME OF FATHER: Geo Harbert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Co Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Co Md

14 Informant: Mrs. Maggie Tunnell

(Address) 1151 N. Calhoun St

15 Filed SEP 6 - 1923 19 ROBERT R. KRAMER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 5th 1923

17 I HEREBY CERTIFY, That I attended deceased from August 18th 1923. to Sept 5th 1923

that I last saw h[illegible] alive on Sept 5th 1923

and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Cancer Uterus Metastasis Left Inguinal & Femoral Glands

(duration) 1 1/2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Physical

(Signed) Lew. N. Rosenberg M. D.

9-5, 19 (Address) 7218 N. Howard Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery — DATE OF BURIAL: Sept 7 1923

20 UNDERTAKER: Clarence E. Wright & Bro Inc — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

D78888

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D78888

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Corsina Green Notre Dame Convent

(a) RESIDENCE. NO. Baltimore Md ST., WARD. Epsmith H.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 28 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Green

11 BIRTHPLACE OF FATHER (city or town) Co Fermanagh (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Bridget Dolan

13 BIRTHPLACE OF MOTHER (city or town) Co Cavan (State or country) Ireland

14 Informant Mt Hope Retreat. (Address)

15 Filed SEP 6 - 1923 ROBERT J. KRAUTER Registrar. Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1923

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1923, to Sept 6, 1923, that I last saw h.. alive on Sept 4, 1923, and that death occurred, on the date stated above, at 6.20 a m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Chemical - Physical

(Signed) Milton P. Hill, M. D.

, 19 (Address) 1715 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Natch Cliff Md.	Sept 7 1923
20 UNDERTAKER	ADDRESS
Frank C. Fink	915 N Gay

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78889 D78889

CERTIFICATE OF DEATH.

179

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (a) No. [redacted] ST., 5 WARD)

2-FULL NAME Samuel Renaudo

(a) RESIDENCE NO 307 Colvin ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stephine Renaudo

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	years		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work [redacted]
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Rosa Renaudo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Stephine Renaudo 3 [redacted]

15 Filed SEP 6 1923, 192 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 — 192 3

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Gry. Burns 2 to 3 days
Alcohol Epilepsy
a Contributory (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism (duration) yrs. mos. ds.

(Signed) [redacted] (Coroner.) 1056 Lexington St. (Address) Balto

Give the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ... yrs., ... mos., ... ds. In the State ... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL Sept 7 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E York St

TION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

D78890

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 ✓ D78890

1-PLACE OF DEATH

City of BALTIMORE: (No. 3816 Fait ave St., 26 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maurice K. Toy

(a) Residence No. 3816 Fait ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Myrtle a Toy

6-DATE OF BIRTH (month, day and year) Sept 10-1870

7-AGE. 52 yrs. 11 mos. 28 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Timber Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Port Penn, Del.

PARENTS.

10-NAME OF FATHER, Alex. Toy.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), New Jersey

12-MAIDEN NAME OF MOTHER, Hester Holten

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), New Jersey

14-

(Informant) Myrtle a. Toy

(Address) 3816 Fait ave

15-

Filed SEP 6 1923, 192

ROBERT R. KRAUTER, Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 4-1923

17- I HEREBY CERTIFY, That I attended deceased from Sept, 1923 to Sept 4 1923

that I last saw h. living on Sept 4 1923

and that death occurred, on the date stated above, at 7.50 P m.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H Goshara D

Sept 5. 1923 (Address) 3100 Harford Road

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Oakland DATE OF BURIAL Sept 6 1923

20-UNDERTAKER Burkhardt Bros ADDRESS 1732 Eager st

In plain terms, so that it may be properly examined. See instructions on back of certificates.

D78891

HEALTH DEPARTMENT—CITY OF BALTIMORE

From 5-10 East St. on May 5 1923 to Mercy Hospital

D78891

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. ~~911 Hillman~~ 5-10 E. 7. R. St., 5 Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME David Scott.

(Residence in Baltimore: No. ~~911 Hillman~~ 5-10 E. 7. R. St.; yrs. 44 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word)
Male	Colored	Married

6-DATE OF BIRTH. March 15 1888
(Month) (Day) (Year)

7-AGE. 35 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) W. Langman

9-BIRTHPLACE. (State or Country) Baltimore

PARENTS.

10-NAME OF FATHER. Howard Scott.

11-BIRTHPLACE OF FATHER. (State or Country) Baltimore

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER. (State or Country) Baltimore

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William Scott.

(Address) 911 Hillman

15-

Filed SEP 6 1923 ROBERT R. KRAUTER Registrar.
Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. 9 - 5 - 23
(Month) (Day) (Year)

I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest and (Inquest, autopsy or inquiry.) thereon and ~~from~~ the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gunshot Wound
Stab wound in chest
Homicide

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. C. Riley M. D.
(Coroner)

Sept 6 192 3 (Address) 1659 Bruce

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Laurel Country	Sept 5th 1923
20-UNDERTAKER.	ADDRESS
George F. Ruth	735 Hayford Ave.

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D78892

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D78892

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1833 N. Duncan Street ST., 8 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Zinkand

(a) RESIDENCE NO. 1833 N. Duncan Street ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Late Michael Zinkand

6 DATE OF BIRTH (month, day, and year) 11/7/1869

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or min.
53	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm. Huff

11 BIRTHPLACE OF FATHER (city or town) Washington, D.C.
(State or country)

12 MAIDEN NAME OF MOTHER Anna Dietrich

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Baltimore, Md.

14 Informant Mrs W. W. Walker
(Address) Elsewhere, Md.

15 Filed SEP 6 - 1923 19 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 30, 1923, to Sept 4, 1923, that I last saw her alive on Sept. 4, 1923, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. F. Herzog M.D. M. D.

Sept 5, 1923 (Address) 1303 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
HOLY CROSS CEMETERY MAC	9/7/ 1923
20 UNDERTAKER Albert L. Waltz Jr	ADDRESS 1606 N. Chester St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D78893

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. 182 D78893

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Off Fells Point. ST., 10 WARD)

2-FULL NAME Albert Harms.

(a) RESIDENCE NO. 814 Greenmount Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) February 20, 1914.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	9	5	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Richard E. Harms.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Lena A. Christ.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Lena A. Wooden. (mother)
(Address) 814 Greenmount Ave.

15 Filed SEP 6 1923, 192 ROBERT B. KRAUTER, Registrar
Burial Permit Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Missing August 13, 1923 192
Found September 4, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Accidentall fall overboard.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) Otto M. Leonhardt M. D. (Coroner)

Sept. 6, 1923 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery Sept 6 1923 DATE OF BURIAL

ADDRESS

20 UNDERTAKER Elmer W. Courtleis ADDRESS 924 E Eager St

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

Gorski

D78894

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-001 ✓

D78894

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph Hospital ST., W WARD)

2-FULL NAME Walter Gorsky.

(a) RESIDENCE NO. 2021 Bank, ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 30 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2 about	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Stanislaus Gorski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Wanda Rydzewska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs Stanislaus Gorski
(Address) 2021 Bank St

15 Filed SEP 6 1923 ROBERT R. KRAUTER, Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 28, 1923, to Sept 5, 1923; that I last saw [illegible] alive on Sept 5, 1923; and that death occurred, on the date stated above, at 9:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(Duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Lymphosarcoma,

(Duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Autopsy?

(Signed) [illegible] M. D.

(Address) St. Joseph Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	Sept 8 1923

20 UNDERTAKER John M Weber ADDRESS 1803 Bank St

KEEP SAFELY

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78895 1-001 ✓ D78895

1-PLACE OF DEATH — REGISTERED NO. C.....

CITY OF BALTIMORE: (No. 521 N. Central Ave ST.; 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph F. Furniance

(Residence in Baltimore: No. 521 N Central Ave St.; Life yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.)
M	C	Married

6-DATE OF BIRTH, ... (Month) 7 (Day) 1 (Year)

7-AGE, 44 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Tea-dealer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Balto Md.

PARENTS.

10-NAME OF FATHER, Joseph Furniance

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Elliott

(Address) 1725 E Fairmount Ave

15- SEP 6 - 1923 ROBERT R. KRAUTER, Registrar. Burial Permit

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 2 (Day), 1923 (Year).

17- I HEREBY CERTIFY, That I attended deceased from Aug 10 1923, to Sept 2 1923, that I saw him alive on Sept 2 1923, and that death occurred, on the date stated above, at 3 45 p.m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ..... yrs. ..... mos. 23 ds.

CONTRIBUTORY (Secondary) Intestinal Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R F Young M. D.

9/5, 1923. (Address) 1729 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Ashburn Cemetery	Sept 6, 1923

20-UNDERTAKER.	ADDRESS
Wm R. G. Elliott	1725 E Fairmount Ave

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78896

CERTIFICATE OF DEATH.

114 D78896

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1808 Nd. Ave ST. 17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fray allen

(a) RESIDENCE NO. 1808 Maryland ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas allen

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince George Va,

PARENTS

10 NAME OF FATHER Thomas Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Joseph Coupler

(Address) 1808 Maryland ave.

15 Filed SEP 6 - 1923 ROBERT N. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-4 1923

17 I HEREBY CERTIFY, That I attended deceased from 8-29-23, 19..... to 9-4-, 1923.

that I last saw h[illegible] alive on ", 19 ,

and that death occurred, on the date stated above, at 8 P, m.

The CAUSE OF DEATH* was as follows:

Acute Tracheobronchitis

(duration) yrs mos 7 ds.

CONTRIBUTORY (Secondary) Heat

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M Calder M. D.

9-4-1923 (Address) 1524 Druid Hill ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Petersburg Va — DATE OF BURIAL Sept 6 1923

20 UNDERTAKER Mrs. R.G. Elliott — ADDRESS 1225 Eastlands

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78897 ✓ 44 D78897

CERTIFICATE OF DEATH.

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 112 S. Broadway ST.: V WARD)

2-FULL NAME Mr Frederick G. Hoerner

(a) RESIDENCE. No 112 S. Broadway ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 58 yrs. ... mos. ... ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ Katie A Hoerner

6 DATE OF BIRTH (month, day, and year) Aug 18 - 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	—	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm R Hoerner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Wegy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katie A Hoerner
(Address) 112 S Broadway

15 Filed SEP 6 1923 19 ROBERT A. KRAMER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9 - 4 - 1923

17 I HEREBY CERTIFY, That I attended deceased from March 15th 1923 to Sept 4th 1923, that I last saw h[illegible] alive on - - 1923, and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Hepatic Carcinoma

(duration) ... yrs. 11 mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Jacob L Weiner, M. D.

9-5, 1923 (Address) 30 S B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Matthews Cemetery	Sept 7 1923

20 UNDERTAKER Henry Lutz ADDRESS 1203 W. Broadway

D78898 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 D78898

CERTIFICATE OF DEATH. 9

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1306 ENSOR ST. St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Elizabeth Knott

(Residence in Baltimore: No. 1306 Ensor St. St.; yrs. 75 mos. 1 ds. 7)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (write the word.)
female	white	widow

6-DATE OF BIRTH. July 29/48 1.....
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
75 yrs. 1 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER, John Wesley

11-BIRTHPLACE OF FATHER, (State or Country). Balto Md.

12-MAIDEN NAME OF MOTHER, Mary Ann Martin

13-BIRTHPLACE OF MOTHER, (State or Country). Bal to. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Howard C. Knott

(Address) 1805 E. 33rd St.

15- SEP6-1923 ROBERT R. KRAUTER, Registrar.
Filed ..... 19.. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 5/23 192....
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial Failure

(Found dead in bed, history of

"heart trouble)

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. S. Poe M. D.
(Coroner.)

9/6/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

London Park Sept 8, 1923

20-UNDERTAKER, ADDRESS 1203

Henry Lutz W. Broadway

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78809

D78809

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 225 N castle ST., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Heine Sr.

(a) RESIDENCE NO. 225 N castle ST., WARD

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Heine

6 DATE OF BIRTH (month, day, and year) 4 February 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Driver 023

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Henry Smith Baltimore

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Charles Heine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kat Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Catherine Heine (Address) 225 N castle st

15 Filed SEP 6 1923 19 ROBERT R. KRAUTER, Registrar

Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1923, to Sept 4, 1923, that I last saw h[illegible] alive on Sept 4, 1923, and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH* was as follows:

Partial Carcinoma Stomach.
diabetes

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael A. Abrams, M. D.

Sept 6, 1923 (Address) 1360 Eutaw place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Sept 7 1923
20 UNDERTAKER Geo C. Miller	ADDRESS 2334 Jefferson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78900 D78900

CERTIFICATE OF DEATH.

113

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 3rd Ave - Wagners Pt ST., 25 WARD)

2-FULL NAME Gloria Angeline Jacobs

(a) RESIDENCE No. 109 - 3rd ave - Wagners Pt ST., 25 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 16 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) May 19 1923

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Infant do

(c) Name of employer Infant

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Clarence Jacobs

11 BIRTHPLACE OF FATHER (city or town) Saco -
(State or country) Maine

12 MAIDEN NAME OF MOTHER Dorothy M. Reese

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Maryland

14 Informant Clarence Jacobs.
(Address) Wagners Pt Md

15 Filed SEP 6 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1923, to Sept 5, 1923, that I last saw her alive on Sept 3, 1923, and that death occurred, on the date stated above, at 1 10 a. m.

The CAUSE OF DEATH* was as follows:
Acute Gastro Enteritis.

..... (duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) .....
..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) William Stick M. D.

Sept 6, 1923 (Address) 816 - Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bachmans Cemetery	Sept 6 1923
20 UNDERTAKER John F Denny	ADDRESS 715 E 3 Alley

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78901

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 D78901

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Kalevoda

(a) RESIDENCE NO. Curtis Bay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1923.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Curtis Bay
(State or country) Maryland

PARENTS

10 NAME OF FATHER Louis Kalevoda

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Mary Soustek

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs Mary Kalevoda
(Address) Church at Curtis Bay Md

15 Filed , 19 Registrar

ROBERT A. KRAUTER
SEP 6 1923 Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 19 23.

17

I HEREBY CERTIFY, That I attended deceased from Sept 5, 1923, to Sept. 5, 1923, that I last saw him alive on Sept. 5, 1923, and that death occurred, on the date stated above, at 9:50 P. m.

The CAUSE OF DEATH* was as follows:

Indigestion - intestinal - acute
with diarrhoea - acute.

(duration) yrs. mos 7 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Signs & symptoms

(Signed) John M. Edmunds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A A Co	Sept 8 19
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

21

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78902

CERTIFICATE OF DEATH.

31 V

D78902

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. F Dengle

(a) RESIDENCE NO. 768 St. Peter ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D. C.

PARENTS

10 NAME OF FATHER Valentine Dengle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Kuntz

13 BIRTHPLACE OF MOTHER (city or town) Wash., D. C. (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed SEP 6 1923 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-4 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug. 27, 1923, to Sept 4, 1923, that I last saw him alive on Sept 4, 1923, and that death occurred, on the date stated above, at 1.55 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. X-ray

(Signed) Claude B. Hume M. D.

9-6, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	9-6 1923
20 UNDERTAKER James Dignan & Son.	ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D78903

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital. ST. 25 WARD)

REGISTERED NO. 188-0017 D78903

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Peter Ziloito.

(a) RESIDENCE NO. 1111 Curtis Ave ST. Curtis Bay. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? 2 yrs. -- mos. -- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -------.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer. 040
(b) General nature of industry, business, or establishment in which employed (or employer) Balto. Car and
(c) Name of employer Foundry Co.

9 BIRTHPLACE (city or town) (State or country) Lithuania.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Mr. Bennett.
(Address) Balto Car and Foundry Co.

15 Filed SEP 6 1923, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5th, 192 3.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of Pelvis, Rupture of Urethra and Rectum Sepsis. Crushed between 2 cars. Accidental death.

.....(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) Otto Reinhardt M. D.
(Coroner.)

Sept. 5th. 192 3. (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death? Accident
Aug. 17, 1923. Balto Car & Foundry Co.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross a.a. DATE OF BURIAL: Sept 7 1923

20 UNDERTAKER: John Grebliunas ADDRESS: 425 S. Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D78904

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78904

131

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 20 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Fannie Gibbons

(a) RESIDENCE NO. 1903 W Pratt ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not Known

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
77	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Not Known

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) "
(State or country) " "

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country) "

14 Informant Self - Fannie Gibbons
(Address) 1903 W Pratt

15 Filed SEP 6 - 1923 16 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1923, to Sept 5, 1923, that I last saw her alive on Sept 5, 1923, and that death occurred, on the date stated above, at 7.35 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia

Coma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy + clinical picture

(Signed) Karl Steinmuller, M. D.

9/5, 1923 (Address) 327 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Sept 7 1923
20 UNDERTAKER	ADDRESS
John J. Fields	1200 W Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78905

33 D78905

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Chapel Gate Lane

CITY OF BALTIMORE: (No. ..... ST., 28 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H. Sterley Jr.

(a) RESIDENCE NO. Chapel Gate Lane. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July. 14 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER Charles H. Sterley

11 BIRTHPLACE OF FATHER (city or town) Balto. Co.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Louetta Plitt

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Md.

14 Informant Charles H. Sterley
(Address) Chapel Gate Lane

Filed ..... 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6, 1923.

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1923. to Sept 6, 1923.

that I last saw him alive on Sept. 6, 1923.,

and that death occurred, on the date stated above, at 6:15 A m.

The CAUSE OF DEATH* was as follows:

Tuberculous peritonitis

(duration) 0 yrs. 7 mos. 0 ds.

CONTRIBUTORY (Secondary) Tuberculosis ulc

(duration) 0 yrs. 7 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore, Md.

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Von Pirquet

(Signed) D. C. Wheeler Smith 2d, M. D.

9/6/23, 1923 (Address) Baltimore. Seven Apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Sept. 7, 1923
20 UNDERTAKER	ADDRESS
Joseph. B. Cook	1003 N. Calvert St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC... TION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Glandular

Spec.—1-10-21—M&T—1500 Blks.

165987
D78906

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78906

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Johns Hopkins Hospital.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. " " " ST., 9 WARD)

2-FULL NAME Abraham Cousynse. Rotterdam, Holland.

(a) RESIDENCE NO. 51 Alcamada St. - ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widowed,

5a If married, widowed, or divorced
~~HUSBAND of~~ ~~(or) WIFE of~~ Elizabeth (Daughter),

6 DATE OF BIRTH (month, day, and year) 1873.

7 AGE: 50 (Years) — (Months) — (Days) — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Seaman.
(b) General nature of industry, business, or establishment in which employed (or employer): " 086
(c) Name of employer: " —

9 BIRTHPLACE (city or town) (State or country): Holland.

PARENTS
10 NAME OF FATHER: Jacob Cousynse
11 BIRTHPLACE OF FATHER (city or town) (State or country): Holland.
12 MAIDEN NAME OF MOTHER: Heinke Laeff.
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Holland.

14 Informant (Address): Record. JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

APR 6-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Aug. 30 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 26, 1923, to Aug 30, 1923, that I last saw him alive on Aug 30, 1923, and that death occurred, on the date stated above, at 10 5/6 A. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia, Pneumococcus septicemia

(duration) ..... yrs. ..... mos. 8 ds.

CONTRIBUTORY (Secondary) —— (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Brest.

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Sputum + blood cultures

(Signed) R.R. Nannon, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Commissioner Health.

JOHNS HOPKINS HOSPITAL

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78907

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D78907

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Green

(a) RESIDENCE NO. 127 Schroeder ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Jacob Green

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Annie Duncan

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Municipal Hospital Records
(Address)

15 Filed SEP 6 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-3 1923

17

I HEREBY CERTIFY, That I attended deceased from June 31, 1923, to Sept 3, 1923,
that I last saw him alive on Sept 3, 1923
and that death occurred, on the date stated above, at 2 10 m.

The CAUSE OF DEATH* was as follows:

Syphilis
Syphilitic Aortitis
Aortic Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab

(Signed) Claude B. Drane M. D.

9-6, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL: SEP 6 - 1923

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

Commissioner of Health.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78908

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78908

CERTIFICATE OF DEATH.

198

1-PLACE OF DEATH

Registered No. C.....

City of BALTIMORE: (No. 2nd Gen. Hop. St., 4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME..... James Redd

(Residence in Baltimore: No. 423 State St. St., 4 yrs., ... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
male	colored	Married

6-DATE OF BIRTH, about 1859
(Month) (Day) (Year)

7-AGE, 75 yrs. ..... mos. ..... ds. If LESS than 1 day, ... hrs. or ..... min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)..... General

9-BIRTHPLACE, (State or Country). Va.

PARENTS.

10-NAME OF FATHER, James Redd

11-BIRTHPLACE OF FATHER, (State or Country), Va.

12-MAIDEN NAME OF MOTHER, unknown

13-BIRTHPLACE OF MOTHER, (State or Country). Va.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm. Wilson

(Address) 318 Pine St.

15-

Filed ..... 192.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 3, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to incised wounds. about 10 min.
(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Homicide (over)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Hennessy M. D.
(Coroner.)

Sept. 6, 1923 (Address) 702 Edmonson Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL,	DATE OF BURIAL,
Hannibal Va	9-6-23

20-UNDERTAKER, Daniel Carter ADDRESS 916 Co ave

Robert P. Harrison
Burial Permit Clerk.

PC-1923

STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78909

CERTIFICATE OF DEATH.

90 D78909

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 1808 E. Biddle St., 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Katherine Bayne

(a) Residence No. 1808 E. Biddle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 7 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-~~Single, Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of George E. Bayne

6-DATE OF BIRTH (month, day and year) June 16 1870

7-AGE. 53 yrs. 7 mos. 21 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) 837

(c) Name of employer

9-BIRTHPLACE (city or town) Paca (State or Country),

PARENTS.

10-NAME OF FATHER, John Bohs

11-BIRTHPLACE OF FATHER (city or town) Germany (State or Country),

12-MAIDEN NAME OF MOTHER, Agnes Dettling

13-BIRTHPLACE OF MOTHER (city or town) Germany (State or Country),

14- (Informant) Elizabeth Shuttle

(Address) 1714 E. Biddle

15- Filed ..... 19.. Registrar.

Robert P. Harrison,

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 6 1923

17- I HEREBY CERTIFY, That I attended deceased from Aug 20 1923 to Sept 6 1923

that I last saw h. alive on Sept 5 1923

and that death occurred, on the date stated above, at 5 30 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac

(Duration) 10 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(Duration) yrs. 10 mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) [illegible], M. D.

Sept 6 1923 (Address) 1201 N Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF ~~BURIAL~~, CREMATION OR REMOVAL Baltimore Cem Co DATE OF BURIAL, Sept 8 1923

20-UNDERTAKER ADDRESS William Cahill 502 E Nath Ave

Filled in by the Undertaker, as that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

6-1923

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78910

CERTIFICATE OF DEATH.

57 D78910

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 889 N Fayette ST., 18 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Medora Nelson.

(a) RESIDENCE NO. 889 N Fayette ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or ~~Divorced, (write the word)~~: Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hugh Nelson

6 DATE OF BIRTH (month, day, and year): Apr 23 1859.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thomas M Duncan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Sarah Leonard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs Drasel

(Address) 889 N Fayette St..

15 Filed ..... 19 ..... Registrar

Robert F. Garrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1 ..... 1918 ..... to Sept 4 ..... 1923.

that I last saw her alive on September 3 1923.

and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Duration 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) ~~~~

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~~~~

Did an operation precede death? ~~ Date of No

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Henry C Cook, M. D.

(Address) 1200 N. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: Sept 7, 1923

20 UNDERTAKER: Wm. Cook — ADDRESS: 502 East North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH City of BALTIMORE: (No. Franklin Sq. Hospital Ward)

Registered No. C.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Lewis

(Residence in Baltimore: No. 528 N. Bruce St.; Yrs. 16 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-Single, Married, Widowed or Divorced (Write the word.)
Male	Colored	Single

6-DATE OF BIRTH, ... 1891
(Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
32 yrs. mos. ds.	hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Labor
(b) General nature of industry, business, or establishment in which employed (or employer): Odd

9-BIRTHPLACE, (State or Country). Va

PARENTS.

10-NAME OF FATHER, Don't know

11-BIRTHPLACE OF FATHER, (State or Country) Don't know

12-MAIDEN NAME OF MOTHER, Don't know

13-BIRTHPLACE OF MOTHER, (State or Country) Don't know

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Maggie Brown

(Address) 528 Bruce St.

15-

Filed SEP 8 1923, 192 Robert P. Harrison, Registrar. Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 4 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Auto Accident

Multiple Fractures

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock

(Duration) yrs. mos. ds.

(Signed) Wm Curtis Pugh M.D.
(Coroner.)

Sept 6 1923 (Address) 443 E Eager

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Mt Lebanon Cemetery	Sept 9 1923
20-UNDERTAKER.	ADDRESS
David Taylor	916 Eutaw

Aids in case of death from plague, cholera or virus, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Blks.

D78912

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

43 D78912

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No. 448 E 22nd ST., 17 WARD)

2-FULL NAME Joseph Thomas Gaffney.

(a) RESIDENCE No. 448 E. 22nd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
44	5	-	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Clerk 004

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad

(c) Name of employer American Express Co.

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER John Jaffrey

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Mary Cosgrove

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mrs. Katie D. Frances (Address) 448 E. 22nd St.

15 Filed ..... 19 ..... Registrar

PE-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/4 1923

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1923, to Sept 4, 1923, that I last saw h.. alive on Sept 4, 1923, and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Pulmonary Oedema.

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Mouth about

(duration) yrs. 7-8 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 2/20/23.

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) J. J. Roberts M. D.

, 19 (Address) 1500 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bonnie Brae Cem. DATE OF BURIAL Sept 7, 1923

20 UNDERTAKER Bernard A Fink ADDRESS 1156 Washington Blvd

Robert P. Harrison, Burial Permit Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78913

CERTIFICATE OF DEATH.

90 D78913

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3603 Sycamore St. ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret E. Hailer

(a) RESIDENCE NO. 3603 Sycamore St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 27, 1852

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
71 yrs.	11	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer) ood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co. Md.

PARENTS

10 NAME OF FATHER James Hailer

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary Mullin

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mary J. Craig

(Address) 3606 Sycamore St

15 Filed SEPT-1923. ROBERT N. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 5 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 29, 1923, to Sept. 5, 1923, that I last saw h[illegible] alive on Sept. 5, 1923, and that death occurred, on the date stated above, at 4.30 P.m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) / yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. T. Hennessy, M. D.

Sept. 5 1923 (Address) 2702 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL 9/8. 1923

20 UNDERTAKER Harman F Burger ADDRESS 3631 Falls Rd.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78914

CERTIFICATE OF DEATH.

58-091 D78914

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3031 Eastern Ave ST., 1 WARD)

2-FULL NAME Elizabeth Diehl

(a) RESIDENCE NO. 3031 Eastern Ave ST., 3 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Diehl

6 DATE OF BIRTH (month, day, and year) November 19-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	65	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Magnas Meister

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Baschel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Minnie Swayne

(Address) 310 S. East Ave

15 Filed SEPT-1923 ROBERT R. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1923

17 I HEREBY CERTIFY, That I attended deceased from June 10 1922, to Sept. 4th 1923. that I last saw her alive on Sept 3rd 1923 and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 1 yrs. 2 mos 24 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Count

(Signed) D.C. Jones, M. D.

(Address) 1011 Edmondwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Pauls Cemetery — DATE OF BURIAL: Sept 7 1923

20 UNDERTAKER: L. Sander & Sons — ADDRESS: 1710 Fleet St.

Spec.—1-10-21—M&T—1500 Blks.

16615 D78915 Surg

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 46 D78915

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Roberta France.

(a) RESIDENCE NO. Reston, Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred LIFE yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female White

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Joseph E France

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE: Years 58 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Adolf Simon

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Margaret Tormey

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant JOHNS HOPKINS HOSPITAL Record (Address)

15 Filed SEP 7 1923 19.. ROBERT R. KRAMER Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 3. 1923. to Sept 5 1923.

that I last saw her alive on Sept 5 1923.

and that death occurred, on the date stated above, at 4.40 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor (Carcinoma metastasis from ovarian carcinoma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? Yes Date of Sept 5 1923

Was there an autopsy? Yes

What test confirmed diagnosis? Pathological exam

(Signed) Warfield Mc Prior M. D.

8/6 1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: Sept 7 1923

20 UNDERTAKER: John C. Mitchell

ADDRESS: 1201 W Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78916

CERTIFICATE OF DEATH.

90 D78916

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, NO. 1305 W. Lanvale ST., 16 WARD)

2-FULL NAME Percy Taneyhill White

(a) RESIDENCE NO. 1305 W. Lanvale ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

length of residence in city or town where death occurred 29 yrs. 11 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mildred White

6 DATE OF BIRTH (month, day, and year) Sept. 9, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .. min.
	29	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Agt.

(b) General nature of industry, business, or establishment in which employed (or employer) Agent

(c) Name of employer Greene & Albaugh Balto

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER J. Wesley White

11 BIRTHPLACE OF FATHER (city or town) Annapolis
(State or country) Md.

12 MAIDEN NAME OF MOTHER Alice McDonell

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Mrs. J. Wesley White
(Address) 1305 W. Lanvale St

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1923

17 I HEREBY CERTIFY, That I attended deceased from ....., 1923, to Sept 5, 1923,
that I last saw him alive on Sept 5, 1923,
and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation —
(general edema)

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Mitral regurgitation

(duration) 11 yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) MB Cummins Md, M. D.

9/5, 1923 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Sept 8 1923

20 UNDERTAKER Wm J. Dickus & Sons. ADDRESS North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78917

CERTIFICATE OF DEATH.

24-001 D78917

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1005 N. Calhoun ST.: 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Walker

(a) RESIDENCE. No. 1005 N. Calhoun ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Paul Hemp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Paul Hemp
(Address) 1005 N. Calhoun St.

15 Filed ..., 19... ...
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1923, to Sept 4, 1923, that I last saw h[illegible] alive on Sept 4, 1923, and that death occurred, on the date stated above, at 11:22 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

7-6. 1923 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	9/4 1923

20 UNDERTAKER James H. Dennis ADDRESS 1305 [illegible]

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78918 90 D78918

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST.; 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Barnes

(a) RESIDENCE NO. 1564 N. Fremont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	widowed

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or min.
53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Susan Adams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Municipal Hospital Records (Address)

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5- 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 31, , 1923. to Sept 5 , 19 23

that I last saw h~~e~~alive on Sept 5 , 19 23

and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (Degenerative) Myocardial Insufficiency

(duration) yrs. 6 mos (history) ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude S. Brace, M. D.

9-5, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn.	9/8 1923
20 UNDERTAKER James Holmes	ADDRESS 1303 Pennsylvania Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78919 D78919

CERTIFICATE OF DEATH.

169

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Off Hawkins Point. ST., 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Alner.

(a) RESIDENCE NO. 822 S. Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) January 25, 1869.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	7	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mariner.
(b) General nature of industry, business, or establishment in which employed (or employer) Of
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Henry Russelberg.
(Address) 822 S. Broadway.

15 Filed SEP 7 - 1923, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 1 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by drowning.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Otto Bernhardt (Coroner) M. D.

Sept. 5, 192 3 (Address) 1011 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL 5/9/7 1923

20 UNDERTAKER John F Denny — ADDRESS 715 Light St.

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

16605

D78920

HEALTH DEPARTMENT—CITY OF BALTIMORE

155 D78920

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 10 WARD)

2-FULL NAME William Poole

(a) RESIDENCE NO. 1116 Mosher St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1913.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ... min.
	10 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School. 440

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Earl C. Poole

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Josephine Craig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant JOHNS HOPKINS HOSPITAL Record (Address)

15 Filed SEP 7 - 1923 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1923, 19 ... to Sept 6, 1923, 19 ..., that I last saw him alive on Sept 6, 1923, 19 ..., and that death occurred, on the date stated above, at 7 45 A. m.

The CAUSE OF DEATH* was as follows:

Acute Osteomyelitis

Staphylococcus Septicemia

(duration) ... yrs. ... mos. 8 ds.

CONTRIBUTORY (Secondary) Staphylococcus Septicemia (duration) ... yrs. ... mos. 8 ds.

18 Where was disease contracted if not at place of death? 1116 Mosher St

Did an operation precede death? Yes Date of 9-3-23

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood Culture,

(Signed) J. L. Reichert M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL Sept 8th 1923

20 UNDERTAKER Jerome Enright ADDRESS 1641 Ram

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78921

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

17 D78921

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Josephs Hospital, 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Erhardt

(a) RESIDENCE No. 2617 Fleet St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 8 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 7th 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	20	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Lawrence Erhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Jennie Doerfler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Jennie Erhardt. (Address) 2617 Fleet St.

15 Filed ..., 19... Registrar

SEP 7 - 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 31, 1923, to Sept 3, 1923, that I last saw him alive on Sept 3, 1923, and that death occurred, on the date stated above, at 5.10 A. m.

The CAUSE OF DEATH* was as follows:

Acute Gangrenous Ruptured Appendicitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Diffuse Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Aug 31, 1923

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms and findings

(Signed) T. Norwood Wilson M. D.

, 19 (Address) St. Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem DATE OF BURIAL Sept 7th 1923

20 UNDERTAKER Lilly + Feiler ADDRESS 403 S. Wolfe St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

78922

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78922

113

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 95 W. Lanvale ST., 11 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Murphy

(a) RESIDENCE NO. 95-W-Lanvale ST., 11 WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 25 ds. How long in U. S., if of foreign birth? — yrs. 0 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): June-12-1923

7 AGE — Years: — Months: 2 Days: 25 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Frank L. Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country): town Md

12 MAIDEN NAME OF MOTHER: Leila Stigl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Maryland

14 Informant: Mrs Elizabeth F. Murphy (aunt)

(Address): 95 W Lanvale

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 6 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 28, 1923, to Sept 6, 1923, that I last saw him alive on Sept 6, 1923, and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) ... yrs. ... mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J E W Talbott, M. D.

, 19 (Address) 1353 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery

DATE OF BURIAL: Sept 6 1923

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. WOODEN, ...)

ADDRESS: 108 W. NORTH AVE.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

78923
D78923

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Marciukowska

D78923

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2815 Fait Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Josefa Marciukowska

(a) RESIDENCE No. 2815 Fait Ave, ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Stefan Marciukowski

6 DATE OF BIRTH (month, day, and year): Mar. 11, 1867

7 AGE: Years 56 Months 5 Days 27 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Dzyerzon Town, Poland.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Stefan Marciukowski,

(Address) 2815 Fait Ave

15 Filed ..... 19 .....

ROBERT R. KRAUTER, Registrar

Sept 8 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 5 1923

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1923, to Sept. 5, 1923, that I last saw him alive on Sept. 5, 1923 and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cancer of Stomach

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Andrew Kuntowski, M. D.

, 19 (Address) 2529 Eastern Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary, — DATE OF BURIAL: Sept 8 1923

20 UNDERTAKER: M. F. Sadowski, — ADDRESS: 1705 S. Ann

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78924

CERTIFICATE OF DEATH.

1131 D78924

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603 Paradise Ch, ST.; 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Butler,

(Residence in Baltimore: No. 1603 Paradise St. St.; ..yrs, 1 mos. 7 ds)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, July 29, 1923 (Month) (Day) (Year)

7-AGE, ..yrs. 1 mos. 7 da.

If LESS than 1 day, ...hrs. or.....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Charles H. Butler

11-BIRTHPLACE OF FATHER (State or Country), Md

12-MAIDEN NAME OF MOTHER, Lizzie Young

13-BIRTHPLACE OF MOTHER (State or Country), Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas H Butler

(Address) 1603 Paradise St

15-

SEP 7 1923

ROBERT R. ... Burial Permit Clerk

Filed....., 191.....

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 4, 1923 (Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Aug 31 1923, to Sept 4 1923, that I saw h.r alive on Aug 3 1923, and that death occurred, on the date stated above, at 7A, m.

The CAUSE OF DEATH* was as follows:

Pneumo-Septicemia

..... (Duration) ...yrs. ...mos. 4 ds.

CONTRIBUTORY (Secondary) .....

..... (Duration) ...yrs. ...mos. ...ds.

(Signed) Jesse Ebaugh M. D.

Sept 4, 1923 (Address) 701 W. Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn

DATE OF BURIAL, 9/5, 1923

20-UNDERTAKER Samuel T Hawley & H Biddle

ADDRESS 578

CAUSE OF DEATH to be plain terms, as that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

D78925

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

14-001 D78925

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 Tyson ST., 11 WARD)

2-FULL NAME alice Gouphs

(a) RESIDENCE No. 419 Tyson ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Dec. 6 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 10

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Lizzy Gant
(Address): 419 Tyson

15 Filed SEP 7 1923 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): September 4th 23

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1923. to September 4, 1923.
that I last saw her alive on September 4, 1923.
and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

apoplexy

Dropsy + Bright disease (duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Bright disease and Dropsy (duration) yrs. 5 mos. 16 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Dr GW Kennard M. D.
9-6, 1923 (Address) 708 Enson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Sept 7 1923
20 UNDERTAKER: Mrs R. G. Elliott	ADDRESS: 1224 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78926 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-09 D78926

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST. 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jennie Woodson

(a) RESIDENCE NO. 1434 Belvidere ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Municipal Hospital Records (Address)

15 Filed SEP 7 1923, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 4 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1922 to Sept 4, 1923.

that I last saw her alive on Sept 4, 1923,

and that death occurred, on the date stated above, at 3 0 m.

The CAUSE OF DEATH* was as follows:

Senile Deterioration

Arterio-sclerosis

Hypertension

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Claude S. Horan, M. D.

9-6, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetry — DATE OF BURIAL Sept 7 1923

20 UNDERTAKER Mrs. R.A. Elliott. — ADDRESS 1225 Rohland Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78927 D78927

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ... ST. 11 WARD)

2-FULL NAME George Vandegrift

(a) RESIDENCE NO. 614 Calvert ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence

6 DATE OF BIRTH (month, day, and year) Aug 28 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Jose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Margaret White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant JOHNS HOPKINS HOSPITAL (Address)

15 Filed ... 19 ... ROBERT R. KRAUTER, Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1923, to Sept 6, 1923, that I last saw him alive on Sept 6, 1923, and that death occurred, on the date stated above, at 3 45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis, chronic Myocarditis

~~Myocardial insufficiency~~

Syphilitic,

(duration) 2 yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) 25 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Wassermann

(Signed) R. R. Hannen, M. D.

7/6, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Sept 10 1923
20 UNDERTAKER George J. Smith	ADDRESS 852 N. Gilmor St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78928

CERTIFICATE OF DEATH.

31 ✓ D78928

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1847 Wilhelm ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George M. Carson

(a) RESIDENCE NO. 1847 Wilhelm ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lillian M. Carson (nee Leary)

6 DATE OF BIRTH (month, day, and year): May 22, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Iron Worker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Chesapeake Iron Works

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: George M. Carson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Lillian M. Carson

(Address) 1847 Wilhelm St

15 Filed SEPT - 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 4 1923

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to Sept. 4, 1923, that I last saw him alive on Sept 4, 1923, and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Bacteriological

(Signed) Edgar E. Travers M. D.

, 19 (Address) 1525 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Sept 7, 1923

20 UNDERTAKER: Harry N. Witzke ADDRESS 1531 W. Lombard St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

FILE • ASK • SEARCH

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78929

CERTIFICATE OF DEATH.

65-002 D78929

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2108 Eagle ST., 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Oliver Clipper,

(a) RESIDENCE No. Glenburnie, Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred All deceased life spent in Balto. (non-resident give city or town and State) with exception of 4 mos. in Glenburnie, Md. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced (Husband of) or (Wife of) Husband of Ella A. Clipper

6 DATE OF BIRTH (month, day, and year) Aug. 27th, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	—	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 080

(b) General nature of Industry, business, or establishment in which employed (or employer) D Z Sp & Store

(c) Name of employer Leader Rahn Coblentz Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Geo. Clipper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Ella A. Clipper (Address) Elizabeth Lane Glenburnie Md.

15 Filed SEP 7 1923 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6, 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept. 6, 1923 to Sept. 6— 1923.

that I last saw h— alive on Sept. 6— 1923,

and that death occurred, on the date stated above, at 10.45 A. m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease.

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Martha L. Bredemeyer, M. D.

9/6, 1923 (Address) 2007 Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery DATE OF BURIAL Sept 8th 1923

20 UNDERTAKER G B Wappert ADDRESS 2236 Fred'k Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Form C.H.D. M&T—1500 Bks.

D78930

16616 8,

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 113 D78930

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. " " " ST., 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Downey.

(a) RESIDENCE NO. Annapolis, Md - R.F.D. ST., #3, WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Only for duration of stay in hospital yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male,

4 COLOR OR RACE: White,

5 Single, Married, Widowed, or Divorced, (write the word): Single,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Downey (father)

6 DATE OF BIRTH (month, day, and year): Sept 17, 1922,

7 AGE: Years 1, Months —, Days 20, If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child, (N)

(b) General nature of industry, business, or establishment in which employed (or employer): —,

(c) Name of employer: —,

9 BIRTHPLACE (city or town) (State or country): Md.,

PARENTS

10 NAME OF FATHER: John Downey,

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Goldie Wingate,

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.,

14 Informant (Address): Records JOHNS HOPKINS HOSPITAL,

15 Filed SEPT 1923 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1923, to Sept 6, 1923, that I last saw him alive on Sept 6, 1923, and that death occurred, on the date stated above, at 8 15 P. m.

The CAUSE OF DEATH* was as follows:

Eczema

Tuberculosis

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary): Diarrhoea (not dysentery)

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? X

(Signed) H. H. Mitch, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Annapolis Md — DATE OF BURIAL: Sept 7 1923

20 UNDERTAKER: Jas. S. Sayler Sons — ADDRESS: Annapolis Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78931

CERTIFICATE OF DEATH.

58-001

D78931

1-PLACE OF DEATH Hebrew Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No.) ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elias Atlas

(a) RESIDENCE. NO. 103 N. Gilmore ST., WARD. D

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Atlas

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store 634

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Moses Atlas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sarah —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) L. Lewis 1439 E. Baltimore St.

15 Filed SEP 7 - 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 7, 1923, to Sept 6, 1923, that I last saw h in alive on Sept 6, 1923 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Infected Laceration

(duration) yrs. mos. 24 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isadore L. Levy, M. D

, 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Wash. Road	Sept 7 1923

20 UNDERTAKER Jack Lewis, 1439 E. Balto.

ADDRESS

Spec.—1-10-21—MAT—1500 Blks.

D78932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74001 D78932

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 401 Forest Road ST. 25th WARD)

2-FULL NAME Elizabeth Cocker

(a) RESIDENCE No. 481 Forest Road ST., 27th WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Cocker.

6 DATE OF BIRTH (month, day, and year) 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Old

(b) General nature of industry, business, or establishment in which employed (or employer) Lady at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Peter Goris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Lour Kuod

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Clout Kuod.

14 Informant Mrs J C Cuddihy
(Address) 401 Forest Rd R.P.

15 Filed SEPT 7 1923 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept-6-1923

17 I HEREBY CERTIFY, That I attended deceased from Dec-26, 1921, to Sept-6, 1923, that I last saw h.e alive on Sept-6-1923, and that death occurred, on the date stated above, at 7-30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 8 mos 10 ds.

CONTRIBUTORY (Secondary) Senile Arterio-Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Pathologic

(Signed) M. Gibson Forty, M. D.

9/6, 1923 (Address) 722 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem. New York	9-8 1923

20 UNDERTAKER H W Kusin & Sons Co ADDRESS Mitchell & Orchard.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state what it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10-001

D78933

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 10 WARD)

2-FULL NAME Jerry Sleator

(a) RESIDENCE No. 921 E. Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Sleator

11 BIRTHPLACE OF FATHER (city or town) (State or country) Easton Shore, Md.

12 MAIDEN NAME OF MOTHER Amelia Grace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co. Md.

14 Informant Jerry Sleator (Address) 921 E. Madison St.

15 Filed SEP 7 1923 ROBERT R. KRAMPF Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 18, 1923. to Sept 4, 1923. that I last saw her alive on Sept 4, 1923, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Senile Debilitas

(Autopsy confirms The above)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia 4 days

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Wm. J. Sadler, M. D.

19 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Sept 7 1923

20 UNDERTAKER Chas. H. Johnson ADDRESS 716 N. Carlin St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78934

CERTIFICATE OF DEATH.

D78934

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 315 S. Bentalou ST., 70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Knopp.

(a) RESIDENCE NO. 315 S. Bentalou ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gotlard Knopp.

6 DATE OF BIRTH (month, day, and year) Mar 23" 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .. min.
	76	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Frederick Sadosky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Klaus

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs Rose Klein. (Address) 315 S. Bentalou St.

15 Filed SEP 7 - 1923 16 ROBERT N. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5" 1923. 19

17

I HEREBY CERTIFY, That I attended deceased from Aug 18, 1923, to Sept-5-23, 1923,

that I last saw h Er alive on Sept-5-23, 1923,

and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach & Liver

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. S. Smith, M. D.

9.6. 1923 (Address) 118 N Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery | DATE OF BURIAL Sept 8" 1923

20 UNDERTAKER Geo L. Schnaal | ADDRESS 2101 Frederick Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

078935 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-00 078935

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3305 E Pratt ST., 76 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate B. Sweeney

(a) RESIDENCE NO. 3305 E Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? ~~Age~~ yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms. so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be carefully supplied.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hiram C. Sweeney.

6 DATE OF BIRTH (month, day, and year): July 2 1849

7 AGE: Years 74 Months 7 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs W J Works

(Address) 3305 E Pratt St

15 Filed . 19

ROBERT P. HARRISON, Registrar

P 7-1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 5 1923

17

I HEREBY CERTIFY, That I attended deceased from July 11, 1923, to Sept. 5, 1923, that I last saw her alive on August 31, 1923, and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic bronchitis + unresolved pneumonia

(Acute pulmonary hemorrhage - 5 min.)

(duration) yrs. 1½ mos ds.

CONTRIBUTORY (Secondary) Senility + Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Maurice E. Shamer, M. D.

9/7, 1923 (Address) 3300 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chambersburg Pa

DATE OF BURIAL: Sept 8 1923

20 UNDERTAKER: John Sullivan

ADDRESS 2008 Orleans

Spec.—1-10-21—M&T—1500 Bks.

D78936

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78936 OK MFGorsuch

CERTIFICATE OF DEATH.

1-PLACE OF DEATH University Hospital 6 REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Ida McCord

(a) RESIDENCE NO. 113 S Linwood ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) June 17. 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16 years +			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wound around 6 Cans factory $

(b) General nature of industry, business, or establishment in which employed (or employer) Manufacture Cans.

(c) Name of employer Continental Can Co

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry McCord

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Schmitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) University Hospital Records

15 Filed ..., 19 Registrar

P 7-1923

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1923

17

I HEREBY CERTIFY, That I attended deceased from July 25, 1923, to Sept 7, 1923,

that I last saw her alive on Sept 7 - , 1923,

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Benzol Poisoning.

6 (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Factory

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical but findings

(Signed) John M. Edmonds, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	Sept 10 1923
20 UNDERTAKER	ADDRESS
William Cook	502 E Nott

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

D78937

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78937

CERTIFICATE OF DEATH.

X 198

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 Peach Al. ST. 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles W. Leak. (C).

(a) RESIDENCE No 1126 Peach Al. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colpred.	Married.

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ — Alice Leak. (C).

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26	--	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlotte N.C.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Alice Leak. (C). (wife).
(Address) 1126 Peach Al.

15 Filed 1923, 192 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 4th, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest & autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest & autopsy find that said deceased came to his death (Inquest, autopsy or inquiry.) on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage, due to a stab wound in the neck.

Homicide. (durntion) ....yrs. ....mos ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) Otto A. Reinhardt (Coroner.) M. D.

Sept. 5, 1923 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death....yrs., ...mos., ...ds. In the State....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY.

DATE OF BURIAL 192

20 UNDERTAKER

ADDRESS

Robert P. Harrison, Commissioner of Health.

...TION is very important. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

D78938 HEALTH DEPARTMENT—CITY OF BALTIMORE D78938

CERTIFICATE OF DEATH.

REGISTERED NO. 199

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 W. Church St. ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Moore. (C).

(a) RESIDENCE NO. 24 W. Church ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male.	Colored.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Do not know.

14 Informant Police Report.
(Address)

15 Filed 7-1923, 192 Robert F. Harrison, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 2nd, 1923.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest & autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest & autopsy (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull and Intra-cranial Hemorrhage. Struck on the head by a piano stool. Homicide.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) Elton Leonhardt (Coroner) M. D.

Sept. 5th, 1923 (Address) 1014 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY DATE OF BURIAL 192

20 UNDERTAKER ADDRESS

TION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78939

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78939

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Elizabeths Home (St.) 9 (Ward)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Josephine Cornelia Reynolds

(a) RESIDENCE. No. St. Elizabeth's Home (St.) Chestnut Hill Ave (Ward)

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: negro

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years | Months: 8 | Days: 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boston Mass

PARENTS

10 NAME OF FATHER Couldn't obtain

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant

(Address)

15 Filed SEP 7 1923, 19 Robert F. Harrison, Registrar

Burial Permit Cler.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 5 1923

17 I HEREBY CERTIFY, That I attended deceased from August 28, 1923, to September 4, 1923, that I last saw h er alive on September 4, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Lues

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Frank J. Boyd M.D.

Sept 6, 1923 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

SEP 7 - 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

16-977
D 8940

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 16-002
D 8940

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 7 WARD)

2-FULL NAME Roberta Jenkins.

(a) RESIDENCE NO. 6 Churchhill Ave, W. ST. WARD
(Usual place of abode) (Only in hospital)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single.

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~ Archer Jenkins (father)

6 DATE OF BIRTH (month, day, and year) July 22, 1922.

7 AGE Years — Months 1 Days 12 If LESS than 1 day.....hr. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Archer Jenkins

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Ruth Thompson,

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant JOHNS HOPKINS HOSPITAL Records
(Address)

15 Filed SEP 7 1923, 19 Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 3 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 20, 1923, to Sept 3, 1923, that I last saw her alive on Sept 3, 1923, and that death occurred, on the date stated above, at 2:00 p. m.

The CAUSE OF DEATH* was as follows:

Dysentery (bacillary)
Type not determined

(duration) yrs. 2 mos. ? ds.

CONTRIBUTORY (Secondary) X

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Examination of stools

(Signed) A. A. Weed, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

SEP 7 - 1923

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78941

CERTIFICATE OF DEATH.

129 D78941

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4333 Ready ave ST., Havens 27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Sickl

(a) RESIDENCE No. 4311 Ready ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. 11 mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 19 1868

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or min.
54	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Louis D. Sickel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary E. Orth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Elizabeth Stieff

(Address): 4333 Ready ave

15 Filed SEP 7 1923, 19 Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 11, 1923, to Sept. 6, 1923, that I last saw him alive on Sept. 5, 1923, and that death occurred, on the date stated above, at 9.55 A m.

The CAUSE OF DEATH* was as follows:

Chron Interstitial Nephritis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H C Haas, M. D.

9-6, 1923 (Address) 6600 York Rd. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore cemetery — DATE OF BURIAL: Sept 8 1923

20 UNDERTAKER: Chas. G. Black — ADDRESS: 742 W. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CONTRIBUTORY CAUSE is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78942

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78942

31

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 433 N Eden St ST., 5 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Jenkens

(a) RESIDENCE NO. 433. N. Eden St ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. — mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None.

6 DATE OF BIRTH (month, day, and year) November. 1880.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	43.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Jenkens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jane. Bishop

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Ella. Foster

(Address) 433. N. Eden St

15 Filed SEPT 7 1923, 19 ..... Registrar

Robert F. Garrison, Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1923, to Sept 6, 1923,

that I last saw him alive on Sept 6, 1923,

and that death occurred, on the date stated above, at 12.45 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(Mitral regurgitation) (over)

(duration) yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Acute Catarrhal Pneumonia

(duration) yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Lee, M. D.

9/7, 1923 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel. Cemetery Sept 10th 1923

DATE OF BURIAL

20 UNDERTAKER Milton Davis 315 N

ADDRESS Eden St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill*; (*a*) *Salesman*, (*b*) *Grocery*; (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired*, 6 *yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of.....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Suspicious - Tuberculous

Spec.—1-10-21—M&T—1500 Bks.

(See affadavit over)

D78943

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78943

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2534 Druid Hill ave ST., WARD)

2-FULL NAME Daniel O. Kraham

(a) RESIDENCE NO. 2535 Druid Hill ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 6 ~~Feb. 6~~ 1922 ~~1924~~

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	5		

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer ~~August W. Kraham~~

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER August W. Kraham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Germany

12 MAIDEN NAME OF MOTHER Mary ~~Lovelock~~ Landbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant August W. Kraham

(Address) 2534 Druid Hill ave

15 Filed SEP 7 1923, 19 Robert P. Harrison, Burial Permit Clerk

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 24, 1923, to Sept 6, 1923, that I last saw h alive on Sept 6, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Signs

(Signed) Geo Talbott, M. D.

, 19 (Address) 1353 W North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Sept. 8 1923

20 UNDERTAKER George F. Rust — ADDRESS 1735 Harford

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Personally appeared before me this 13th day of September 1923. Mrs Mary V. Krahn Mother of Daniel O. Krahn. who. made affadivit that the date of birth of Daniel O Krahn. is April 6th 1922 instead of Feb. 6-1921.

SEP 13 1923

Seal Mrs Mary V. Krahn

Seal. George H Giese
Notary Public

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78944 100-001 D78944

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 303 N. Exeter ST., 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agostino Tore

(a) RESIDENCE NO. 303 N. Exeter ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sebastiana Acosta

6 DATE OF BIRTH (month, day, and year): Oct. 8-1871

7 AGE: 51 Years 10 Months 29 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fruit Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

045

9 BIRTHPLACE (city or town) (State or country): Italy.

PARENTS

10 NAME OF FATHER: Santo Tore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Maria Tore

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Sebastiana Acosta (Address) 303 N. Exeter St.

15 Filed SEP 7 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/6/23.

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1923, to Sept 6, 1923, that I last saw him alive on Sept 6, 1923, and that death occurred, on the date stated above, at 6.30 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Bronchial Asthma (duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mary L. Ketterlinus M. D. 7, 1923 (Address) 1058 E. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Lawrence Cem. DATE OF BURIAL: 9/8/23

20 UNDERTAKER: Geo J Ruth ADDRESS: 1935 Harford Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78945

CERTIFICATE OF DEATH.

74-001 D78945

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1131 Hanover ST., 23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Casey

(a) RESIDENCE NO. 1131 Hanover ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 2 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	x	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Engineer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Peter Casey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Moran

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Gilbert Harley

(Address) 1114 E. Chase St

15 Filed SEP 7-1923, 19 ... Registrar

Robert P. ... Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 6th, 19... to Sept 7th 1923, that I last saw he alive on Sept 7th, 1923, and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Paralysis (Hemiplegia)

(Cerebral Hemorrhage)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cystitis Bilateral Pyelonephritis

(duration) 2 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry D. Kolb M.D., M. D.

Sept 7th 1923 (Address) 1131 Light

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem.

DATE OF BURIAL: Sept. 10 1923

20 UNDERTAKER: Margaret J. Hynes

ADDRESS: 1422 Light St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78936

CERTIFICATE OF DEATH.

74-001 D78936

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 W. Henrietta ST., 23 WARD)

2-FULL NAME Matilda Robinson

(a) RESIDENCE NO. 119 W. Henrietta ST., WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Richard Robinson

6 DATE OF BIRTH (month, day, and year): ——— 1872

7 AGE: Years 51 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): @ Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kent Island Maryland.

PARENTS

10 NAME OF FATHER: Thomas Saunders

11 BIRTHPLACE OF FATHER (city or town) (State or country): Kent Island Maryland.

12 MAIDEN NAME OF MOTHER: Rosetta ———

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kent Island Maryland.

14 Informant: Walter Bowdley
(Address): 119 W. Henrietta

15 Filed SEP 8-1923, 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept, 6, 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct, 10, 1922, to Sept, 6, 1923, that I last saw her alive on Sept, 6, 1923, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) — yrs. 10 mos — ds.

CONTRIBUTORY (Secondary) Arterio sclerosis - Chr. Interstitial Nephritis (duration) — yrs. ——— mos. ——— ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Urine + Sputum +

(Signed) David Franklin, M. D.

9/7, 1923 (Address) 122 W. 3rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Ct — DATE OF BURIAL: Sept-9 1923

20 UNDERTAKER: C. W. Brown & Son — ADDRESS: 108 W. Mulb

MENTION should be carefully applied. AGE should be stated
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78947 90 D78947

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 132 N. Washington ST.: 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy F. Scott

(a) RESIDENCE. NO. 132 N Washington ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert F. Scott

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Easton Md

PARENTS

10 NAME OF FATHER James S. Collins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Robert F. Scott

(Address) 132 N. Washington St

15 Filed SEP 8 1923, 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9- 6- 1923

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1923, to Sept 6, 1923, that I last saw her alive on Sept 6, 1923, and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular Cardiac disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Thomas, M. D.

9-7-1923 (Address) 822 N. Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gary Green Mount	Sept 10 1923

20 UNDERTAKER ADDRESS

Theodore White 113 W. Saratoga St

Burial Permit Issued

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

166 224
D78948

HEALTH DEPARTMENT—CITY OF BALTIMORE

159 D02
D78948

CERTIFICATE OF DEATH.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 18 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boy Branstead

(a) RESIDENCE No. 1108 W Saratoga St ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. Life mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or) WIFE of~~: Julius Brandstegdt (Father)

6 DATE OF BIRTH (month, day, and year) Sept 6, 1923.

7 AGE — Years: — Months: — Days: 1 day. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Julius Brandsteadt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Constance Froelich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Switzerland

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Record.

15 Filed SEP 8 1923, 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 6, 1923, 19 ..... to Sept 6, 1923, 19 .....

that I last saw him alive on Sept 6, 1923, 19 .....

and that death occurred, on the date stated above, at 8:00 P. M.

The CAUSE OF DEATH* was as follows:

Congenital malformation of the heart

(duration) ..... yrs. Life mos. ..... ds.

CONTRIBUTORY (Secondary) X

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Patient born in hospital.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. N. Wood, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: Sept 8 1923

20 UNDERTAKER: H. C. Feldmann — ADDRESS: 1300 W Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78949

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78949

CERTIFICATE OF DEATH.

X 159-00

REGISTERED NO.

1-PLACE OF DEATH Hebrew Hospital

CITY OF BALTIMORE: (No. H. H. ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Christakos

(a) RESIDENCE. NO. 502 W. Biddle ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July — 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2yrs	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Peter Cheristakos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rebecca Cheristakos

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis Cheristakos

(Address) 502 W. Biddle St

15 Filed . 19 Registrar

EP8-1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 6th 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 28 . 1923 . to Sept 6 . 1923.

that I last saw him alive on Sept 6 . 1923.

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 5 days

CONTRIBUTORY (Secondary) Hydrocephalus dis'ease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Aug 15th

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Howard W. Kent M. D.

. 19 (Address) Hebrew Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	9-10- 1923

20 UNDERTAKER Daniel Easton

ADDRESS 516 Park

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of Occupation is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.).* For persons who have no occupation whatever, write *None.*

Statement of cause of death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease *causing death*), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Bronchio
Congenital.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78950

99-881 D78950

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH U. S. Soft Asy.

CITY OF BALTIMORE: (No. 1401- Division ST., 14 WARD)

2-FULL NAME Vincent Hilton Carder.

(a) RESIDENCE No. 1401 Division St. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12. 1919.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) ..... None

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Cumberland Md

PARENTS

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Hilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant St Vincent Asylum
(Address) 1400 Division

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7. 1923

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1923. to Sept 7, 1923.

that I last saw him alive on Sept 4, 1923.

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Bronchiectasis

(duration) ..... yrs. 2 mos ..... ds.

CONTRIBUTORY
(Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Chas R. Goldthwait M. D.

, 19 (Address) 2735 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL Sept 8 1923

20 UNDERTAKER Martin Tracey Son — ADDRESS 1847 W North

(Burial Permit Clerk.)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78951

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

113 D78951

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3966 Elm Ave ST.: 13 WARD)

2-FULL NAME Charles E Gates

(a) RESIDENCE. No. 3966 Elm Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 23 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Earl Gates

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Fair

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Earl Gates
(Address) 3966 Elm Ave

15 Filed ..... 19 ..... Registrar

SEP 8 1923 Robert P. Harrison Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 7 23rd, 1923, to Sept 8th, 1923,

that I last saw h[illegible] alive on Sept 7th, 1923,

and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Illeo-Colitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Acute

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 3966 Elm Ave

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) T. A. Lillard, M. D.

9/8, 1923 Address) 1527 Mercer St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	Sept 10 1923

20 UNDERTAKER ONEMOWETH & SON ADDRESS 3617 CHESTNUT AVE.

REMOVAL SHOULD BE CAREFULLY ATTENDED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78952

CERTIFICATE OF DEATH.

113 D78952

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 2630 Bernard ST.: 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert F Redmond

(a) RESIDENCE. No. 2630 Bernard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred: Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Singl

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Dec 14 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ind

PARENTS

10 NAME OF FATHER Wm L Redmond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ind

12 MAIDEN NAME OF MOTHER Emma Fair

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Wm L Redmond (Address) 2630 Bernard Ave

15 Filed , 19 Robert F. Curtis Registrar

CP 0 1923

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Sept 7, 1923, that I last saw deceased on Sept 7, 1923, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Teething Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) L A Richardson M. D.

(Address) 1112 W Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	Sept 8 1923

20 UNDERTAKER ADDRESS

CHENOWETH & SON,
3617 CHESTNUT AVE.

CAUSE OF DEATH should be stated EXACTLY. PHYSICIANS should state it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78953

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D78953

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 Singer Ad ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H Shenkel.

(a) RESIDENCE NO. 105 Singer Ad ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sallie Shenkel

6 DATE OF BIRTH (month, day, and year) Dec 9 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Philip Shenkel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Caroline Deibel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sallie M Shenkel. (Address) 105 Singer Ave.

15 Filed Sept 8 1923 Robert M. Garrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7, 1923

17

I HEREBY CERTIFY, That I attended deceased from July 17, 1922 to Sept 7, 1923, that I last saw h alive on Sept 6, 1923 and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Chronic Bright's Disease Arterio Sclerosis, Hypertension

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theodore H. Mosser M. D.

19 (Address) 1013 N. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Sept 8 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E Hoffman

P8-1923

Robert M. Garrison, Health Board Clerk.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78954

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78954

74-001

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William McDowell

(a) RESIDENCE NO. 1769 Homestead ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred: yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma R McDowell

6 DATE OF BIRTH (month, day, and year) April 10 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Thomas McDowell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Mrs Charles E Mayhue 1424 N Broadway

15 Filed SEP 8-1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7, 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec 11, 1922, to Sept 7, 1923

that I last saw him alive on Sept 7, 1923

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis + Hypertension

Left Hemiplegia (Residual)

(Cerebral Hemorrhage)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (Terminal) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Claude A Drane, M. D.

9-7, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem

DATE OF BURIAL Sept 10 1923

20 UNDERTAKER William Lackey 1026 E Oath

ADDRESS

Burial Permit Clerk.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78955

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78955

CERTIFICATE OF DEATH.

31

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 320 - N - Mount St. 19 WARD)

2-FULL NAME Julia Anne Wells

(a) RESIDENCE NO. 320 - Mount ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May - 1908

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or min.
15	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cadiz Ohio

PARENTS

10 NAME OF FATHER: John W. Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country): Somerset Co Md

12 MAIDEN NAME OF MOTHER: Susan Wise

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Somerset Co Md

14 Informant (Address): Virgie Bomford (Aunt) 320 - N - Mount

15 Filed Sept 23, 19.....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9 - 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 15, 1923, to Sept 6, 1923, that I last saw her alive on Sept 6, 1923, and that death occurred, on the date stated above, at 3, 30 a m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Clinical Dx

What test confirmed diagnosis?

(Signed) Walter Jackson, M. D.

, 19 (Address) 618 W Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: Sept 11 1923

20 UNDERTAKER: A. Jones

ADDRESS: [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78956

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

34 D78956

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital ST., 21 WARD)

2-FULL NAME Annie McLane

(a) RESIDENCE No. 831 Clifford ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Thomas Green

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Harriet Haines

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Municipal Hospital Record
(Address)

15 Filed SEP 8 1923, 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 5 1923

17

I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1922, to Sept 5, 1923

that I last saw her alive on Sept 5, 1923,

and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Pott's Disease of Spine

Spastic Paraplegia (Secondary to Pott's of spine)

(duration) 1 yrs. (4 mos.) ..... ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(Terminal) (duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray, Lab., Autopsy

(Signed) Claude G. Haines M. D.

9-5, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 6 19
20 UNDERTAKER	ADDRESS
A Jones	1113 Lilian

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78957

CERTIFICATE OF DEATH.

D78957

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 126-S-Stocton ST., 17 WARD)

2-FULL NAME Henretta Bolton

(a) RESIDENCE No. 126-S-Stocton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Bolton

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	54	7	4	

8 OCCUPATION OF DECEASED 041

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Works herself

(c) Name of employer Baltimore

9 BIRTHPLACE (city or town) (State or country) ...

PARENTS

10 NAME OF FATHER William Bolton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Anne Arundel Co

12 MAIDEN NAME OF MOTHER Lydia Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Mary's Co Md

14 Informant Tom Brown
(Address) 126 S Stocton

15 Filed SEP 8 1923, 19 ... Registrar
Robert P. Harrison,
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-5 1923

17 I HEREBY CERTIFY, That I attended deceased from 9-3, 1923, to 9-5, 19 23

that I last saw her alive on 9-5, 19 23

and that death occurred, on the date stated above, at 5:10 9 m.

The CAUSE OF DEATH* was as follows: Mitral Insufficiency

Acute

(duration) 9 yrs. 2 mos. 9 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis Cardiac

(duration) 9 yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of ...

Was there an autopsy? No

What test confirmed diagnosis? Walter J Jones

(Signed) ... M. D.

, 19 (Address) 618 W Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Sept 8th 19
20 UNDERTAKER	ADDRESS
A. Jones	111 Gilmor

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No other history.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78958 ✓ 113 D78958

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1414 N. Luzerne Ave ST.: 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise Harriett Love (LOVE)

(a) RESIDENCE. No. 1414 N. Luzerne Ave ST., ... WARD. .....
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 21/1922

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md County

PARENTS

10 NAME OF FATHER John H. Love

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER Rose L. Reilly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Rose L. Reilly
(Address)

15 Filed SEP 6 - 1923 19 Robert P. Hartman Registrar
Central Record CLERK.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/7/ 1923

17 I HEREBY CERTIFY, That I attended deceased from August 25, 1923, to September 6, 1923, that I last saw h.. alive on September 6, 1923, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(duration) yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank J. Ayd M. D.

Sept 8, 1923 (Address) 200 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cemetery	Sept 8 1923
20 UNDERTAKER	ADDRESS
E. LeRoy Steffler	1252 Mod Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... may be very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78959

CERTIFICATE OF DEATH.

113 ✓ D78959

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 708 S Roston St.; 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Teresia Mary Krysiak

(Residence in Baltimore: No. 708 S Patterson St.; ....yrs., ...mos. ....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Mary | 4-COLOR OR RACE. W.A. | 5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH. Aug 26, 1922
(Month) (Day) (Year)

7-AGE. 1 yrs. ....mos. ....ds. | If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... NO
(b) General nature of Industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Teresia Krysiak

11-BIRTHPLACE OF FATHER (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER Mary Kaluza

13-BIRTHPLACE OF MOTHER (State or Country). Poland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Krysiak

(Address) 708 S Patterson

15-

Filed....., 191....

Registrar.

SEP 8 1923

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept 7, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 5, 1923, to Sept 7, 1923, that I saw h[illegible] alive on Sept 6, 1923, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....

.....

.....(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

.....(Duration)....yrs....mos....ds.

(Signed) Wilbur H. Post M.D.

....., 191.. (Address) 1913 W Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
St. Stanislaus.	Sept 8th, 1923.
20-UNDERTAKER	**ADDRESS**
W.F. Sadowski.	905 S. Ann St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec. 6-9-19—H. P. Co.—1000 Bks.

D78960

HEALTH DEPARTMENT—CITY OF BALTIMORE

1 ✓

D78960

CERTIFICATE OF DEATH.

101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 W. Fayette ST.: 19 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Rockel Sr.

(a) RESIDENCE. No. 1511 W. Fayette ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. 7 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Catherina Rockel.

6 DATE OF BIRTH (month, day, and year) January 10-1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor

(b) General nature of industry, business, or establishment in which employed (or employer): Cement. 016

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore City Md.

PARENTS

10 NAME OF FATHER Henry Rockel.

11 BIRTHPLACE OF FATHER (city or town) Landerbach (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Habermehl

13 BIRTHPLACE OF MOTHER (city or town) Landerbach (State or country) Germany.

14 Informant Catherine Rockel. (Address) 1511 W. Fayette St.

15 Filed SEP 8-1923, 19

Registrar

Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 8-1923.

17 I HEREBY CERTIFY, That I attended deceased from Sept 2- 1923, to Sept 8- 1923, that I last saw him alive on Sept. 7- 1923, and that death occurred, on the date stated above, at 8:55 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) Influenza.

(duration) — yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Chester Riland, M. D.

9-8-, 1923 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Sept 11 1923
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

(John R. Mitchell)

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78961

D78961

CERTIFICATE OF DEATH.

90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital St. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mitchell. John. R

(a) RESIDENCE No. 3710 Springdale Ave ST. WARD Balto- Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs John Mitchell.

6 DATE OF BIRTH (month, day, and year) Sept. 7, 1843-

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Mitchell. John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant (Address) Johns Hopkins Hospital Records.

15 Filed , 19 Registrar

EPB-1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 6 , 1923 , to Sept 7 , 1923 ,

that I last saw him alive on Sept 7. , 1923 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocardial insuppiciency
Senile state -

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred H. Allen, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Sept 19
20 UNDERTAKER	ADDRESS
George Smith	Holins

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78962

D78962

CERTIFICATE OF DEATH.

REGISTERED NO. 101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 N. Appleton ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pauline Emma Jones

(a) RESIDENCE NO. 912 N. Appleton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 11 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 9-29-1922.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or .... min.
	—	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Edward Uriah Jones

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Reese Foggett.

13 BIRTHPLACE OF MOTHER (city or town) Anne Arundel Co (State or country) Md

14 Informant Emma R. Jones

(Address) 912 N. Appleton St.

15 Filed 9-23-49 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) September 7 1923

17 I HEREBY CERTIFY, That I attended deceased from August 11 , 1923 , to September 7 , 1923 , that I last saw her alive on September 6 , 1923 , and that death occurred, on the date stated above, at 9:10 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. — mos. 13 ds.

CONTRIBUTORY (Secondary) Influenzal Pleurisy

(duration) yrs. — mos. 28 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Chester Ruland, M. D.

9-7, 1923 (Address) 2532 Edmondson Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	Sept 8 1923
20 UNDERTAKER Joseph B Cook	ADDRESS 1003 N. Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78963

HEALTH DEPARTMENT—CITY OF BALTIMORE

D 8963

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1638 N Caroline ST.; 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John A. H. Koller

(a) RESIDENCE. NO. 1638 N Caroline ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Koller

6 DATE OF BIRTH (month, day, and year) 4/15/1855

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	68	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Railroad 07 13

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER John Koller.

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary West.

13 BIRTHPLACE OF MOTHER (city or town) Balto Md.
(State or country)

14 Informant Margaret Koller
(Address) 1638 N. Caroline St

15 Filed SEP 8 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/4/23. 19

17

I HEREBY CERTIFY, That I attended deceased from April 4, 1917 to Sept 24, 1923.

that I last saw h alive on Sept 4, 1923

and that death occurred, un the date stated above, at 7:30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular disease of heart

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John W. Sanderson, M. D.

, 19 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 [illegible] OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem — DATE OF BURIAL: 9/8/23

20 UNDERTA[illegible]: George J. Ruth, 1735 Hanford Av — Balto Md — ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS & [illegible] & state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

D78964

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78964

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 107 West Twenty-seventh St. 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME... Curt C. Saffran

(Residence in Baltimore: No. 107 West Twenty-seventh St.; yrs. 24 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced, (Write the word.)
Male	White	Married

6-DATE OF BIRTH. October (Month) 14, (Day) 1873 (Year)

7-AGE. 49 yrs. 10 mos. 23 ds. If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work..... Retired Saloon
(b) General nature of industry, business, or establishment in which employed (or employer)..... Keeper

9-BIRTHPLACE, (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Adolph Saffran

11-BIRTHPLACE OF FATHER, (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Emma Wageld

13-BIRTHPLACE OF MOTHER, (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)... Mrs. Ellen Saffran

(Address)... 107 West Twenty-seven St

15-

Filed ..... 192.....

Robert P. Garrison, Registrar.

Burial Permit Clerk.

P8-1923

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. ..... (Month) ..... (Day) ....., 192..... (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said..... (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....

.....(Duration).....yrs.....mos.....ds.

CONTRIBUTORY (Secondary) .....

.....(Duration).....yrs.....mos.....ds.

(Signed)..... M. D.
(Coroner)

..... 192... (Address) .....

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Cathedral Cem. DATE OF BURIAL. 9/10/ 1923

20-UNDERTAKER. Henry W. Mears & Son ADDRESS 805 N. Calvert St

that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78965

CERTIFICATE OF DEATH.

74-991 D78965

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2011 Linden Ave. ST., 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Clay Hewitt

(a) RESIDENCE NO. 2011 Linden Ave. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Annie Hill

6 DATE OF BIRTH (month, day, and year) April 12, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Assistant Supt. Balto.

(b) General nature of industry, business, or establishment in which employed (or employer) Fire Patrol & Despatch Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D. C.

PARENTS

10 NAME OF FATHER John Hill Hewitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Estelle Mangin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant William J. Hewitt
(Address) 2011 Linden Ave.

15 Filed SEP 8 1923, 19 ..... Registrar Robert P. Harrison, Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from June, 1923, to Sept 7, 1923, that I last saw him alive on Sept 1, 1923, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Linnaeus E. Beach M. D.

, 19 (Address) 2231 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 9/10/ 1923

20 UNDERTAKER Henry W. Mears & Son — ADDRESS 805 N. Calvert St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78966

CERTIFICATE OF DEATH.

161-001 D78966

REGISTERED NO. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1831 Rutland av ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Baby Strahl (unnamed)

(Residence in Baltimore: No. 1831 Rutland av St.; ....yrs.,....mos.....ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Single

6-DATE OF BIRTH, Sept 8, 1923 (Month) (Day) (Year)

7-AGE, ...yrs....mos. 0 ds.

If LESS than 1 day, 16 hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9-BIRTHPLACE, (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Ruth L. Strahl.

11-BIRTHPLACE OF FATHER (State or Country), Calvert Co Md

12-MAIDEN NAME OF MOTHER Mary L. Ogden

13-BIRTHPLACE OF MOTHER (State or Country) Calvert Co Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Father

(Address) 1831 Rutland av

15- SEP 9 - 1923 ROBERT R. KRAUTER, Registrar.
Filed....., 191.....
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8, 1923 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Sept 7 1923. to Sept 8 1923. that I saw h[illegible] alive on Sept 8 1923. and that death occurred, on the date stated above, at 1130a m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration)....yrs....mos....ds.

CONTRIBUTORY (Secondary) Ex Labor

(Duration)....yrs....mos....ds.

(Signed) J. M. Lazenby M. D.

Sept 8, 1923 (Address) 826 N Carrollton

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Huntingtown Md | DATE OF BURIAL, Sept 9, 1923

20-UNDERTAKER Wm Cook | ADDRESS 502 E Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78967 ✓ D78967

CERTIFICATE OF DEATH. X 10

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 Edmondson ST., ...WARD)

2-FULL NAME Hattie Gorden

(a) RESIDENCE NO. 814 Edmondson ST., ...WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 1922.

7 AGE — Years: 1 — Months: 8 — Days: — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): S.C.

PARENTS

10 NAME OF FATHER Grover Gorden

11 BIRTHPLACE OF FATHER (city or town) (State or country): S.C.

12 MAIDEN NAME OF MOTHER Julia Carson.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S.C.

14 Informant: Lucile Gorden
(Address): S. C.

15 Filed SEP 4 1923 Registrar

ROBERT R. KRAUTER

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9/8 1923

17 I HEREBY CERTIFY, That I attended deceased from 9/5 1923 to 9/8 1923, that I last saw h[illegible] alive on 9/8 1923, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Diptheria

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Burpheller M. D.

9/8 1923 (Address) R/3 Dr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Perry South Carolina

DATE OF BURIAL: Sept 9 1923

20 UNDERTAKER: Edward Bryan

ADDRESS [illegible]

N. B.—Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

~~16197~~ D78968

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78968

31

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., WARD) .....

2-FULL NAME James Standely

(a) RESIDENCE NO. 527 N. Dallas St ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 5 mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: ~~White~~ Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced ~~HUSBAND~~ of ~~(or) WIFE of~~: Francis Standely

6 DATE OF BIRTH (month, day, and year): 1920

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2 yrs	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Francis Standely

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Marie Tubman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): JOHNS HOPKINS HOSPITAL. Record

15 Filed SEP 9 1923 19 ROBERT R. KRAUTER Registrar Burial Permit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 7, 1923

17 I HEREBY CERTIFY, That I attended deceased from Jan 25 1923 19 to Sept 7, 1923 19, that I last saw him alive on Sept 7, 1923 19, and that death occurred, on the date stated above, at 5-45 A M.

The CAUSE OF DEATH* was as follows:

Tuberculous cervical adenitis - 9mos +

Pulmonary tuberculosis - 9mos +

Tuberculous peritonitis - 3mos +

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) X

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy - X-ray

(Signed) H. H. Mech M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge md

DATE OF BURIAL: Sept 10 1923

20 UNDERTAKER: Edward Bryson

ADDRESS 1631 Orleans

N. B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78969

CERTIFICATE OF DEATH.

101-001 D78969

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 815 Ensor ST., 10 WARD)

2-FULL NAME Jacob Becker

(a) RESIDENCE NO. 815 Ensor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Becker

6 DATE OF BIRTH (month, day, and year) — 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery Store

(b) General nature of industry, business, or establishment in which employed (or employer) 24

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1432 Bush

15 SEP 9 - 1923 Filed 19 ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-8 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1923, to Sept 8, 1923

that I last saw him alive on Sept 8, 1923

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

9/9, 1923 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Mt. Carmel

DATE OF BURIAL Sept. 9 1923

20 UNDERTAKER East Lewis, 1431 E. Base St

ADDRESS

N.B.—WRITE PLAINLY. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

D78970

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78970

CERTIFICATE OF DEATH.

129

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Hebrew Hospital St., Ward)

(If death occurred in a hospital or institution, give Its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Izrael Freelander

(Residence in Baltimore: No. 1906 McKean Ave St.; yrs. 35 mos. ds.)

N. B.—Every item of information should be carefully supplied. AGE SHOULD BE STATED EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, Divorced. (Write the word.)
male	white	Widower

6-DATE OF BIRTH. unknown (Month) ..... 1..... (Day) (Year)

7-AGE. 75 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Russia

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER, (State or Country), B

12-MAIDEN NAME OF MOTHER, "

13-BIRTHPLACE OF MOTHER, (State or Country), "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr. Freelander(son)

(Address) 1906 McKean Ave

15-

Filed SEP 9 - 1923 192 ROBERT R. KRAUTER, Registrar.

Burial Permit

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept.8/23 (Month) (Day) 192.....(Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said hig (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremic convulsion

(Chronic Nephritis)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Enlarged Prostate Gland

(Duration) yrs. mos. ds.

(Signed) J. S. Bacon M. D.
(Coroner)

9/8/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Hebrew Herring Run DATE OF BURIAL, Sept 9th 1923

20-UNDERTAKER, Jacob Lewis ADDRESS, 1439 E. Pratt

Spec.—J-10-21—M&T—1500 Bks.

Cook 713 N. Wash

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78971

CERTIFICATE OF DEATH.

44 D78971

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3710 Clairmont ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leonhard A Hamm

(a) RESIDENCE NO. 3710 Clairmont ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Dieterle

6 DATE OF BIRTH (month, day, and year) Feb. 13 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman.

(b) General nature of industry, business, or establishment in which employed (or employer) 162

(c) Name of employer Cash. Can Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Hamm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Priscilla Rineberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katherine Hamm

(Address) 3710 Clairmont St

15 Filed SEP 9 1923 ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 7 1923 to Sept 8 1923

that I last saw h[illegible] alive on Sept 7 1923

and that death occurred, on the date stated above, at 4-30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas 2 mos

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia Absorption

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Lewis M. D.

9/8 1923 (Address) 1128 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Sept	10 1923

20 UNDERTAKER Wm Cook Sept ADDRESS 502 E Lex

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78972 — 31 — D78972

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1535 Light ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Mary Ann Middleton

(a) RESIDENCE. NO. 1535 Light ST., WARD.
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 25 1895

7 AGE — Years: 28 — Months: 0 — Days: 13 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Operator

(b) General nature of industry, business, or establishment in which employed (or employer): 586

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co. Md.

PARENTS

10 NAME OF FATHER: George Middleton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Australia

12 MAIDEN NAME OF MOTHER: Sarah Phillips

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Julia Bryant
(Address) 1353 E 16th St. Canton

15 Filed ..... 19 SEP 9 - 1923 ROBERT R. KRAMER, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1923, to July 7, 1923, that I last saw h.. alive on ....., 19....., and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Indefinite (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. E. Campbell M. D.

(Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Oakland. Carroll Co Md

DATE OF BURIAL: 9/10 1923

20 UNDERTAKER: J. Frew McCully.

ADDRESS: 1286 Fort Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78973

CERTIFICATE OF DEATH.

X 49 D78973

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2-FULL NAME Leon Haas

(a) RESIDENCE NO. Louisville ST., Kentucky WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. 2 mos. ... ds. How long in U. S., if of foreign birth? 8 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or ~~Divorced, (write the word)~~: Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia S. Haas

6 DATE OF BIRTH (month, day, and year): July 16. 1863

7 AGE: Years 60. Months 7 Days 22. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cash Operator

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Kentucky

PARENTS

10 NAME OF FATHER: Moses Haas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Levy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: JOHNS HOPKINS HOSPITAL. (Address)

15 Filed SEP 10 1923, 19 ..... ROBERT B. KRAUTH, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 6 1923

17

I HEREBY CERTIFY, That I attended deceased from July 16 1923, to Sept 8 1923, that I last saw him alive on Sept 8 1923, and that death occurred, on the date stated above, at 7:30 P m.

The CAUSE OF DEATH* was as follows:

Pyonephrosis secondary to Carcinoma of bladder

(duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of July 16 '23

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Charles J. Bidgood, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Louisville Ky. DATE OF BURIAL: Sept. 9. 1923

20 UNDERTAKER: John O. Mitchell ADDRESS: 1201 W. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state mation should be carefully supplied. AGE should CAUSE OF DEATH in plain terms, so that it may b TION is very important. See instructions on back c

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78974

CERTIFICATE OF DEATH.

99-102 D78974

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 N. Port St. ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Augusta Franz

(a) RESIDENCE NO. 822 N Port St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 4 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Franz

6 DATE OF BIRTH (month, day, and year): May 7th 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Charles Franz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Charlotte Ernest

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Howard R. Franz

(Address) 822 N Port St

15 Filed ....., 19.... ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 8th 23

17

I HEREBY CERTIFY, That I attended deceased from 1920 - Oct 1st to Sept 8 1923.

that I last saw h alive on Sept 8 1923

and that death occurred, on the date stated above, at 1815

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis - Asthma -

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac hypertrophy —

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible] M. D.

, 19 (Address) 125 N Howard —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Sept 10th 1923

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78975

CERTIFICATE OF DEATH.

1-001 D78975

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 407 N. Madeira St. WARD) 6

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles Abel

(Residence in Baltimore: No. 407 N. Madeira St.; 12 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) School

6-DATE OF BIRTH, May (Month) 17 (Day), 1911 (Year)

7-AGE, 12 yrs. 3 mos. 20 ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. at School
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Balto

PARENTS.

10-NAME OF FATHER, Adam Abel

11-BIRTHPLACE OF FATHER (State or Country), Balto

12-MAIDEN NAME OF MOTHER Estella Kotaleb

13-BIRTHPLACE OF MOTHER (State or Country), Balto

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Adam Abel

(Address) 407 N. Madeira St.

15- Filed SEP 9 - 1923, 191

ROBERT R. KRAUTER, Burial Permit Clerk

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept (Month) 7 (Day), 1923 (Year)

17- I HEREBY CERTIFY, That I attended deceased from 8-2 1923 to Sept 7 1923

that I saw h[illegible]ive on Sept 7 1923

and that death occurred, on the date stated above, at 1:15 A m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred Rausch M. D.

8, 191 3 (Address) 600 N. Bath

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Holy Redeemer

DATE OF BURIAL, Sept 10, 1923

20-UNDERTAKER Frank Crockson

ADDRESS 1906 Eutaw

N. B.—Every item of information should be carefully supplied. AGE should be given EXACTLY. If DECEASED was an infant, CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-15-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78976

CERTIFICATE OF DEATH.

45 D78976

1-PLACE OF DEATH Bon Secours Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Fayette and Arlington ST., ... WARD 10

2-FULL NAME Miss Margaret M. Campbell

(a) RESIDENCE NO. 241 W. Monroe ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If not resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 18 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	47	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone Op.

(b) General nature of Industry, business, or establishment in which employed (or employer) Hospital

(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Maryland

PARENTS

10 NAME OF FATHER Bernard Campbell

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country) Bernard Campbell

12 MAIDEN NAME OF MOTHER Rose McCullan

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Mrs Mary Campbell
(Address) Lady Lake Fla.

15 Filed SEP 9 1923 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7th 1923

17

I HEREBY CERTIFY, That I attended deceased from June 10th, 1923, to Sept. 7th, 1923, that I last saw h[illegible] alive on September 6th, 1923, and that death occurred, on the date stated above, at 1st p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of colon extending to stomach, with Metastasis of G.I. tract

(duration) yrs. 5 mos ..... ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death? —

Did an operation precede death? yes Date of June 22, 23

Was there an autopsy? No X-ray.

What test confirmed diagnosis? Exploratory Laparotomy

(Signed) ..... M. D.

9/7/1923 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Catholic Cem	9/10/1923
20 UNDERTAKER For Finley Sultan & Fayette	ADDRESS

NOTE—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78977

CERTIFICATE OF DEATH.

90 D78977

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 233 N Pappleton ST., WARD) 16

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Armada Bond

(a) RESIDENCE NO. 233 N Pappleton ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) about 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer None

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Jas Thomas

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) L ?
(State or country)

14 Informant Mary Bond
(Address) 233 N. Pappleton St

15 Filed SEP 9 1923, 192 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ~~(inquest, autopsy or inquiry.)~~ thereon and from the evidence obtained by said ~~(inquest, autopsy or inquiry.)~~ find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Don't Know

(duration) yrs. mos. ds.

(Signed) J K Bond M. D.
(Coroner.)

9-8 1923 (Address) 117 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	Sept 10 1923
20 UNDERTAKER	ADDRESS
Brown & Freeland & Schroder	114 W.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78978

CERTIFICATE OF DEATH.

45 D78978

1-PLACE OF DEATH

REGISTERED No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2307 Druid Hill Ave., ST., WARD) 15

2-FULL NAME Carrie Mayerson,

(a) RESIDENCE No. 2307 Druid Hill Ave., ST., ...
(Usual place of abode) WARD)

Length of residence in city or town where death occurred lifetime, mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Mayerson,

6 DATE OF BIRTH (month, day, and year) Nov. 22nd. 1851.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 27

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Herman Hable,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany,

12 MAIDEN NAME OF MOTHER Rosa Billheimer,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany,

14 Informant Mrs. J. Philipson. (Address) 2307 D.H.Ave.

15 Filed SEP 9 - 1923, 19 ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8th. 1923

17

I HEREBY CERTIFY, That I attended deceased from Dec. 12, 1922, to Sept 8, 1923, that I last saw her alive on Sept 8, 1923, and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Cervix Uteri

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard C. Clark M. D.

Sept 9, 1923 (Address) Latrobe Apts, Charles & Read Sts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew, DATE OF BURIAL Sept. 10th 23

20 UNDERTAKER David Sondheim ADDRESS 118 W. Mt. Royal

N. B.—WRITE LEGIBLY, WITH UNFADING INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N.B.—WHITE PAPER, WITH ENGRAVING—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D78979

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

181-002 D78979

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 432 N. Kenwood Ave.

CITY OF BALTIMORE: (No. ... St., Ward) 10

2-FULL NAME Master August Rettman, Jr.

(a) RESIDENCE NO. 432 N. Kenwood Ave St., Ward ...

(Usual place of abode) (If not resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. 5 mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ... min.
—	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of Industry, business, or establishment in which employed (or employer) — 650

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER August Rettman

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Laura White

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Mother
(Address) 432 N. Kenwood

15 Filed SEP 9 1923 19 ROBERT R. KRAUTER, Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 7 1923

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1923, to Sept 8, 1923

that I last saw h alive on Sept. 4, 1923,

and that death occurred, on the date stated above, at 4 20 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Fractured ribs. Dec'd

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? X-ray of chest.

(Signed) L. C. Bakehel M. D.

19 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL Sept. 10, 1923

20 UNDERTAKER Jos J. Merrason 156 N. Eutaw — ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired, 6 yrs.*). For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Called Dr Potter by phone.
O.K.
Mother or Father probably rolled over on it.
Accidental.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

D78980

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78980

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 808 Rutland Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nathaniel Manuel

(Residence in Baltimore: No. 808 Rutland Ave St.; yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Use word.)
male	black	married

6-DATE OF BIRTH. March 17/1870 (Month) (Day) (Year)

7-AGE. 53 yrs. 5 mos. 19 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: laborer
(b) General nature of industry, business, or establishment in which employed (or employer): lumber

9-BIRTHPLACE, (State or Country). Maryland

PARENTS.

10-NAME OF FATHER, James Manuel

11-BIRTHPLACE OF FATHER, (State or Country), Md.

12-MAIDEN NAME OF MOTHER, Jane Dix

13-BIRTHPLACE OF MOTHER, (State or Country), Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Manuel (wife)

(Address) 808 Rutland Ave

15- Filed ..... 192.....

SEP 9 - 1923 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 5/23 (Month) (Day) (Year) 192....

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said bis (Inquest, autopsy or Inquiry.) inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Probably Tuberculosis

(Duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Bauer M. D. (Coroner.)

9/8/23 192.... (Address) 508 E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Cathay Cemetery DATE OF BURIAL, Sept 9 1923

20-UNDERTAKER, Mrs R C Elliott ADDRESS 1723 Edmondson

D78981 HEALTH DEPARTMENT—CITY OF BALTIMORE D78981

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH — Registered No. C.....

City of BALTIMORE: (No. St. Joseph Hospital ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Mc Cormick

(Residence in Baltimore: No. St. James Home (High nr Gay) ..... St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write word.)
male	white	single

6-DATE OF BIRTH. Nov 1st 1905, 1..... (Month) (Day) (Year)

7-AGE.	If LESS than 1 day,
17 yrs. 10 mos. 7 ds.	....hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... Printer
(b) General nature of industry, business, or establishment in which employed (or employer) ..... No 3

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. August McCormick

11-BIRTHPLACE OF FATHER, (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER. Barbara Mccormick

13-BIRTHPLACE OF MOTHER, (State or Country). Balto. Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Barbara Adams (Mother)

(Address) Back River Park

15- Filed SEP 9 - 1923, 192. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8/23, 192.... (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said his (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicemia (Fell from "RacerDip" at River View Park on May 13th/23 Lacerations over buttocks & broknn leg,) (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (Duration) ..... yrs. ..... (mos. ..... ds.

(Signed) J. S. H. Patton M. D. (Coroner.)

9/9/23 192 (Address) 5pl E. North Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19-PLACE OF BURIAL OR REMOVAL. DATE OF BURIAL.

Oak Lawn Cemetery Sept 11 19 23

20-UNDERTAKER, ADDRESS

Leo McGuire & Son 811 N Gay St

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78982

CERTIFICATE OF DEATH.

10

D78982

REGISTERED NO. N

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bayview Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanche Blake

(a) RESIDENCE NO. 601 Oakland ave ST., Govans WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 19-1919

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — (N)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Daniel Blake

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Mary Morris

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Jane E. Blake

(Address) 601 Oakland Ave. Govans

15 Filed SEP 9 - 1923 49 ROBERT R. KRAUTER, Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1923, to Sept 9, 1923, that I last saw her alive on Sept 9, 1923, and that death occurred, on the date stated above, at 1:50 a m.

The CAUSE OF DEATH* was as follows:

Diphtheria, nasal, tonsillar, pharyngeal laryngeal, (duration) — yrs. — mos 5 ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) — yrs. — mos. 3(?) ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) B Wolfman, M. D.

9/9/23 (Address) Bayview Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Sept 10 1923

20 UNDERTAKER Frank Lassahn Sons — ADDRESS Fullerton

N. B.—WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

D78983

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78983

CERTIFICATE OF DEATH

1-PLACE OF DEATH Church Home Infirmary REGISTERED NO. 47

CITY OF BALTIMORE: (No. 6 St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kavaugh.

(a) RESIDENCE NO. Church Home Inf. ST., WARD Photo

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House duties

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) Pa. (State or country)

PARENTS

10 NAME OF FATHER Patrick Kavagh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Meagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Margaret Kavagh (Address) 249 N. Augusta Phila Pa

15 Filed SEP 10 1923, 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8, 19 23

17 I HEREBY CERTIFY, That I attended deceased from March 27, 19 23, to Sept 8, 19 23,

that I last saw h alive on Sept 8, 19 23,

and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows: Carcinoma of Breast

(Duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Cajetan Parrettini M.D.

19, (Address) Church Home

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Phila Pa. DATE OF BURIAL Sept 9 1923

20 UNDERTAKER John O. Mitchell ADDRESS 1201 N Augusta

N. B.—WHITE PAPER, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Blks.

D78984

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

D78984 129 6

1-PLACE OF DEATH — Registered No.

City of BALTIMORE: (No. 1500 E Baltimore St., 6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. George F. Beil.

(a) Residence No. 1500 E Baltimore St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.)

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Anna Beil

6-DATE OF BIRTH (month, day and year) Oct 29 1877

7-AGE, 45 yrs. 11 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Saloon Keeper

(b) General nature of Industry, business, or establishment in which employed (or employer). Proprietor

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER. John F. Beil.

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Germany

12-MAIDEN NAME OF MOTHER. Anna M. Daum.

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Germany

14-

(Informant). Fred P. Buettner

(Address) 1512 E Balto St.

15-

Filed. SEP 10 1923 ROBERT R. KRAUTER, Registrar. Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 8 '23

17- I HEREBY CERTIFY, That I attended deceased from Feby 7, 1923, to Sept 8, 1923, that I last saw him alive on Sept 8, 1923, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Caleb R Athey, M. D.

Sept 9, 1923 (Address) 1003 Pattersn Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Dek Lawn — DATE OF BURIAL, Sept 10, 1923

20-UNDERTAKER. L. Heemann — ADDRESS 322 N Broadway

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

D78985

HEALTH DEPARTMENT—CITY OF BALTIMORE

89 D78985

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Entaw Place & Nelson St.

Registered No. C.....

City of BALTIMORE: (No. Marlborough Apartments St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Duncan Watkins

(Residence in Baltimore: No. Marlborough Apart. St.; yrs. 5 mos. 13 ds.)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE.	5-Single, Married, Widowed, or Divorced. (Write the word.)
male	white	Married

6-DATE OF BIRTH. March 25 1847
(Month) (Day) (Year)

7-AGE. 76 yrs. 5 mos. 13 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of Industry, business, or establishment in which employed (or employer). Dom't Sash & Door manufacturer

9-BIRTHPLACE, (State or Country). Balto. Md.

PARENTS.

10-NAME OF FATHER. Thos. C. Watkins

11-BIRTHPLACE OF FATHER, (State or Country). Md.

12-MAIDEN NAME OF MOTHER. Eliz. A. Hirsch

13-BIRTHPLACE OF MOTHER, (State or Country). Md.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Gertrude M. Watkins

(Address) Marlborough Apts.

15- Filed SEP 10 1923 ROBERT R. KRAUTER Registrar.
Burial Permit Issued

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 7, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Coroner's Jury (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) no history

(Duration) yrs. mos. ds.

(Signed) J. C. Hemmeter M. D.
(Coroner.)

Sept 8 1923 (Address) 708 N. Eutaw Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).
At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cemetery DATE OF BURIAL. Sept 10 1923

20-UNDERTAKER. Stewart & Moore Co ADDRESS 1080 N. Monroe Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78986

CERTIFICATE OF DEATH.

101-001 ✓

D78986

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 309 N. Paca ST.; 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Glorioso

(a) RESIDENCE. No. 309 N. Paca ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3/4/1910

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	13	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Scholar

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Frank Glorioso

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Carcetta Marina

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Frank Glorioso
(Address) 309 N. Paca St.

15 Filed SEP 10 1923, 19 ROBERT P. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1923, to Sept. 6, 1923, that I last saw her alive on Sept. 6, 1923, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) Philbert Artigiani, M. D.

, 19 (Address) 2942 E. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	9/10/23 19
20 UNDERTAKER	ADDRESS
J. J. Fahey & Son	1318 Eager

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

D78987 D78987

REGISTERED No. C

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 22 N. Montford Ave WARD) 6

(If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Esther Zarimbovitch

(Residence in Baltimore: No. 22 N. Montford Ave St. 18 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX Female | 4-COLOR OR RACE White | 5-SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Widowed

6-DATE OF BIRTH ——, 1857
(Month) (Day) (Year)

7-AGE 66 yrs. mos. ds. | If LESS than 1 day, hrs. or min.?

8-OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE (State or country) Russia

PARENTS

10-NAME OF FATHER Unknown

11-BIRTHPLACE OF FATHER (State or country) Russia

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or country) Russia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. Levin

(Address) 1397 E. Preston

15-

SEP 10 1923

Filed ....., 191

ROBERT R. KRAUTER, Burial Permit Clerk

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16-DATE OF DEATH Sept 10th, 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1922, 191 . to. Sept 9th 1923.
that I saw her alive on Sept 9th/23, 191 .
and that death occurred, on the date stated above, at 12:05 a. m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Liver.

(Duration) 1 yrs. mos. ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) Harris Goldman M. D.

Sept 10, 23, 191 (Address) 1816 W. North Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, or RECENT RESIDENTS)

At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19-PLACE OF BURIAL OR REMOVAL New Rondale | DATE OF BURIAL Sept 12 1923

20-UNDERTAKER Levin | ADDRESS 1397 E. Pr

Spec.—1-10-21—M&T—1500 Bks.

78988

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

'31 D78988

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 E. Preston ST., 10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John R. Fox.

(a) RESIDENCE NO. 907 E Preston ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie E. Fox.

6 DATE OF BIRTH (month, day, and year) Feb. 2 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penn R.R.

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Abner H. Fox.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Catherine Rife

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Carrie E. Fox

(Address) 907 E Preston

15 Filed ....., 19 .....

ROBERT R. KRAUTER, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept. 4, 1923, to Sept 9, 1923, that I last saw him alive on Sept 9, 1923, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

ORW

(duration) yrs. 3 mos 10 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry T. Callenberg, M. D.

9/9, 1923 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount. DATE OF BURIAL: Sept 12, 1923.

20 UNDERTAKER: Coulbourn ADDRESS: 502 E Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Pulmonary Tuberculosis

Spec.—1-10-21—M&T—1500 Blks.

D78989

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D78989

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital St., 7 WARD)

2-FULL NAME Thomas W. Lunsford

(a) RESIDENCE NO. 943 N. Caroline ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) July 13-1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
~~64~~ 63 yrs.		1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm. Lunsford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER ~~E.~~ Thelma Asbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Municipal Hospital Records
(Address)

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1923, to Sept 9, 1923, that I last saw him alive on Sept. 9, 1923 and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Myocardial Insufficiency

(duration) 2 yrs. 3 mos (last) ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Claude B. Kinsey, M. D.

9-9, 1923 (Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western DATE OF BURIAL Sept 12 1923

20 UNDERTAKER Wm Cook ADDRESS 502 E Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D78990 HEALTH DEPARTMENT—CITY OF BALTIMORE

161-002 D78990

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 711 E. Eastern Ave 26th ST., 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George A. Sapp

(a) RESIDENCE NO. 711 E. Eastern Ave 26 ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Aug 22-1923

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Off

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore City (State or country)

PARENTS

10 NAME OF FATHER George A. Sapp

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Carrie A. Schumann

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant George A. Sapp

(Address) Eastern Ave & 26th St.

15 Filed ....., 19.... Burial Permit Clerk.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9th 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 6, 1923, to Sept 9th, 1923, that I last saw him alive on Sept 9th, 1923, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Instrumental injuries received at birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank A. Glantz, M. D.

Sept 9, 1923 (Address) 3244 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	Sept 11 1923
20 UNDERTAKER John Ellriot	ADDRESS 2008 Aliceanna

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-1021—1M-7-1500Bks.

D78991

HEALTH DEPARTMENT—CITY OF BALTIMORE

84 ✓ D78991

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1507 E North Ave ST., 8 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Clifton Bushey Sr.

(a) RESIDENCE NO. 1507 E North Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alberta R King

6 DATE OF BIRTH (month, day, and year) May 11 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer) 006

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Andrew J Bushey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Alberta R Bushey
(Address) 1507 E North Ave

15 Filed SEP 10 1923, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-8 1923

17 I HEREBY CERTIFY, That I attended deceased from May, 1923, to Sept. 1, 1923.

that I last saw him alive on Sept. 8, 1923,

and that death occurred, on the date stated above, at 7.53 A.m.

The CAUSE OF DEATH* was as follows:

BRAIN TUMOR (GLIOMA)

(duration) 1 yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? Yes Date of Aug. 10, 1922.

Was there an autopsy? No.

What test confirmed diagnosis? Operation

(Signed) John A. Dorsey M.D.

, 19 (Address) 1008 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem — DATE OF BURIAL Sept 12 1923

20 UNDERTAKER John Merritt — ADDRESS 3604 Eastern

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Non-Malignant

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78992

CERTIFICATE OF DEATH.

90 D78992

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1014 S. Paca ST., 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert D. Long.

(a) RESIDENCE NO. 1014 S. Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Long (Downs)

6 DATE OF BIRTH (month, day, and year) July 19

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or min.
50	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Contr.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robt. D. Long Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine Wolfe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cumberland Md.

14 Informant Mrs Emma V. Long (Address) 1014 S. Paca St

15 Filed SEP 10 1923, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 th 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 17, 1921, to Sept 9, 1923, that I last saw h alive on Sept 9, 1923 and that death occurred, on the date stated above, at 8:30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) J. M. Lamb Jr M. D.

(Address) 826 N. Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem DATE OF BURIAL Sept 12 1923

20 UNDERTAKER J. F. Cowan & Son ADDRESS 901 Hollins St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HERMAN H. KRAUTER, Burial Permit Clerk

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78993

CERTIFICATE OF DEATH.

38 D78993

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 100 Madeira ST., 6 WARD)

2-FULL NAME William Robinson

(a) RESIDENCE No. 100 N. Madeira ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Elsie Robinson

6 DATE OF BIRTH (month, day, and year): Dec 25/1888

7 AGE: Years 34 Months ~~Dec~~ 13 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Junk-man

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: William Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mary Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Margaret Bumby

(Address): 100 N. Madeira

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept. 7/ 19 23

17 I HEREBY CERTIFY, That I attended deceased from Aug 1/ 19 23 to Sept 7/ 19 23

that I last saw him alive on Sept 6/ 19 23

and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Heart Failure

(Coma)

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary): Chronic Bronchitis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) Richard Wesley Jr. M. D.

, 19 (Address) 1514 E Balt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel

DATE OF BURIAL: Sept 10 1923

20 UNDERTAKER: John W Henderson

ADDRESS 1602 E Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificate.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Censue and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic). "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *scpticemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

Probably Lunatic

Spec.—1-10-21—M&T—1500 Bks.

D78994

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78994

CERTIFICATE OF DEATH.

179

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1625 W Pratt ST. 14 WARD)

2-FULL NAME Chas. F Parnell

(a) RESIDENCE NO. 1625 W Pratt ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
Male	Col	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
60?	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Jos Parnell

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Elizabeth Jacobsen
(Address) 1625 W Pratt

15 Filed ..... 19..... ROBERT R. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/6 1923

17 I HEREBY CERTIFY, That I attended deceased from 6/ , 1923 , to 9/6 , 1923 ,
that I last saw h[illegible] alive on 9/6 1923 ,
and that death occurred, on the date stated above, at 10 AM m.

The CAUSE OF DEATH* was as follows:
Chr. nephritis
Aortic Insufficiency

(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Burk Gaither, M. D.

9/6, 1923 (Address) 2139 Dill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel cemetery

DATE OF BURIAL Sept 10 1923

20 UNDERTAKER Frost & Gibson

ADDRESS [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D78995

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

146 D78995

REGISTERED NO.....

1-PLACE OF DEATH Hebrew Hospital.

CITY OF BALTIMORE: No. Monument & Rutland Ave. WARD 3

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sadie Friedman

(a) RESIDENCE. No. 308 So. Carolina St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? 14 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joel Freeman

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particulor kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E. Baltimore

15 Filed . 19 ROBERT O. KRAUTER Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/10 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/17, 1923, to 9/10, 1923, that I last saw h-, alive on 9/10, 1923, and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Puerperal septicaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia.

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes. Date of 8/12/23.

Was there an autopsy? S. D.

What test confirmed diagnosis?

(Signed) Isidor L. Levy, M. D.

. 19 (Address) Hebrew Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt. Carmel

DATE OF BURIAL 9/10 1923

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D78996 ✓

CERTIFICATE OF DEATH.

D78996

90

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Aged Home ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chepra Cohen.

(a) RESIDENCE NO. 115 Arsgirth st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. 10 mos. ds. How long in U. S., if of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work old age

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E Baltimore St

15 Filed ..., 19 ROBERT R. KRAUTER, Registrar

SEP 10 1923

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-9 1923

17 I HEREBY CERTIFY, That I attended deceased from July 8th, 1923, to Sept 9th, 1923.

that I last saw her alive on Sept 8th, 19...

and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jacob L Weinman, M. D.

9 10, 1923 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run — DATE OF BURIAL 9/10 1923

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

D78997

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

D78997

CERTIFICATE OF DEATH.

45 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1817 Madison Ave ST. 14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ivy V. Wachter

(a) RESIDENCE NO. 1817 Madison Ave ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Chas S. Wachter

6 DATE OF BIRTH (month, day, and year) Dec 14 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	51	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 237

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lewistown, Fredk Co. Maryland.

PARENTS

10 NAME OF FATHER Mr. John C. Derr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wash. Co. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Kemp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Co Md

14 Informant (Address) Chas. S Wachter (husband) 1817 Madison Ave.

15 Filed SEP 10 1923 ..... 19 ROBERT R. KRAUTER, Burial Permit Clerk. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1923

17 I HEREBY CERTIFY, That I attended deceased from Oct 19 1922 to Sept 8 1923.

that I last saw her alive on Sept 8 1923

and that death occurred, on the date stated above, at 9.30 8 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration) 3 yrs. 4 mos — ds.

CONTRIBUTORY (Secondary) — (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of June 1921

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Grant Elford, M. D.

19 (Address) 1418 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Utica Frederick Co Md — DATE OF BURIAL Sept 12 1923

20 UNDERTAKER Chas. G. Block — ADDRESS 742 W. Fourth Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

~~078998~~

CERTIFICATE OF DEATH. ✓ H 078998

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mo Gen Hospt ST. 15 WARD)

2-FULL NAME Mrs Mattie Longfellow (Mabel Routhen)

(a) RESIDENCE NO. 3812 Dorchester St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M.W. Longfellow

6 DATE OF BIRTH (month, day, and year) Feb 18 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	51	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hamilton Ohio

PARENTS

10 NAME OF FATHER Wm H. Routhen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Alice Dudley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant M.W. Longfellow (Address) 3812 Dorchester St

15 Filed SEP 10 1923 . 19 ROBERT R. CRAIG Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9-7-23

17 I HEREBY CERTIFY, That I attended deceased from 8-23-23 .19 . to 9-7-23 .19 , that I last saw h[illegible] alive on 9-7-23 .19 , and that death occurred, on the date stated above, at 4.25 p m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus Coma
Septicaemia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Clinical & Lab findings

What test confirmed diagnosis?

(Signed) [illegible] M. D.

. 19 (Address) Mo Gen Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem DATE OF BURIAL Sept 10 1923

20 UNDERTAKER Wm J Dickmeyer Sons ADDRESS Norfolk Va

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

18999 HEALTH DEPARTMENT—CITY OF BALTIMORE 18999

CERTIFICATE OF DEATH. 167-001

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2022 Linden Ave St., 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George E Mann

(Residence in Baltimore: No. 2022 Linden Ave St.; yrs., mos., ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widower

6-DATE OF BIRTH. Oct (Month) 7 (Day) 1923 (Year)

7-AGE. 85 yrs. 10 mos. ds. If LESS than 1 day, hrs. or mtn.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. Retired
(b) General nature of Industry, business, or establishment in which employed (or employer). Shoe Merchant

9-BIRTHPLACE, (State or Country). City

PARENTS.

10-NAME OF FATHER. Unk Mann

11-BIRTHPLACE OF FATHER, (State or Country). England

12-MAIDEN NAME OF MOTHER. Mary Nelson

13-BIRTHPLACE OF MOTHER, (State or Country). England

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J Burgess McConnell

(Address) 2900 Carlisle

15-

Filed ..... 192.....

ROBERT R. KRAUTER, Burial Permit Clerk.

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept (Month) 7 (Day) 1923 (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by said Inquest (Inquest, Autopsy or Inquiry.) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gas Poison
Suicide

(over)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John J. Morrissey M. D. (Coroner.)

Sept 9 1923 (Address) 3632 Roland Ave

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents).

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL.	DATE OF BURIAL.
Greenmount Cem	Sept 10 1923
20-UNDERTAKER.	ADDRESS
W. L. Richardson	Walk Ave

Remarks .....

Illuminating Gas

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive Engineer, Civil Engineer, Stationary Fireman,* etc. But in many cases, especially industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary) may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid,* etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

Statement of Cause of Death.—Name, **first,** the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid the use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Broncho-pneumonia* ("pneumonia," unqualified, is indefinite); *Tuberculosis of the lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough, Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.; Bronchopneumonia* (secondary), 10 *ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart Failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child birth or miscarriage, as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

Certificates will be returned for additional information which may give any of the following diseases, without explanation as the sole cause of death:

Abortion,	*Hemorrhage,*	*Meningitis,*	*Phlebitis,*
Cellulitis,	*Gangrene,*	*Miscarriage,*	*Pyemia,*
Childbirth,	*Gastritis,*	*Necrosis,*	*Septicemia,*
Convulsions,	*Erysipelas,*	*Peritonitis,*	*Tetanus.*

The following must be referred to a Coroner:

Deaths due to accident (if criminal negligence possibly involved): *Suicides, Homicides, Abortions (if induced),* whether death is directly or indirectly due to same.

Spec.—1-10-21—M&T—1500 Bks.

D79090 **HEALTH DEPARTMENT—CITY OF BALTIMORE** D79090

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (ST.) 13 (WARD)

2-FULL NAME Josephine Disney

(a) RESIDENCE NO. 4122 Falls Road (ST.) 13 (WARD)
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Chas. W. Disney

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
56 yrs.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H'mfr
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Ed. Kelly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know

12 MAIDEN NAME OF MOTHER Sophia Eaton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Chas Disney
(Address) 4122 Falls Rd. Balto.

15 Filed ....., 19 ..... Registrar

SEP 10 1923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1923, to Sept 9, 1923, that I last saw her alive on Sept 9, 1923, and that death occurred, on the date stated above, at 5:35 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis
Pulmonary oedema

(duration) 1 yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Injection Gall Bladder (Supposed)
Gen Peritonitis.
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? (Res.)

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms Blood pressure

(Signed) Vernon F. Kelly M. D.

(Address) 3705 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem. DATE OF BURIAL Sept 12 1923

20 UNDERTAKER A. B. Marshall ADDRESS 3539 Falls Rd

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

ROBERT R. KRAUTER, REGISTRAR OF VITAL STATISTICS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Asso.]

Statement of Occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death.—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid —probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN.

No Signs of Tuberculosis or Cancer

Spec.—1-10-21—M&T—1500 Bks.

D79001

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79001

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 2229 E. Federal ST., 8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude M. Cole

(a) RESIDENCE NO. 2229 E. Federal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 7 mos. 9 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Thomas C. Cole

6 DATE OF BIRTH (month, day, and year) March 1st 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Bartholama Shirk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gertrude Bergmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr Thomas C. Cole

(Address) 2229 E Federal St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 10 1923

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1923, to Sept 10, 1923

that I last saw him alive on Sept 10, 1923

and that death occurred, on the date stated above, at 4:15 p. m.

The CAUSE OF DEATH* was as follows:

Coronary Occlusion

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Ernest C. Edwards M. D.

19 (Address) 928 N Carlton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Sept 12 1923

20 UNDERTAKER	ADDRESS
Henry Horch Son	1301 E Eager St

ROBERT R. KRAUTER,

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79002 HEALTH DEPARTMENT—CITY OF BALTIMORE D79002

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 116 Hawthorn Rd Hamilton ST.: 10 WARD)

2-FULL NAME Stephen Woodside Peck

(a) RESIDENCE. NO. 817 N. Central Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 2 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Peck.

6 DATE OF BIRTH (month, day, and year) June 22nd 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis A. J. Peck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah McLain

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mary J. Peck (Address) 817 N. Central Ave

15 Filed ..... 19..... Registrar

SEP 10 1923

(Geo. F. Harrison)
Director of Vital Statistics

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9. 1923.

17 I HEREBY CERTIFY, That I attended deceased from Aug 28, 1923, to Sept 9, 1923, that I last saw him alive on Sept. 7, 1923, and that death occurred, on the date stated above, at 7.45 P.m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) ..... yrs. ..... mos. 12 ds.

CONTRIBUTORY (Secondary) Valvular heart disease; hypertension, (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) ..... M. D.

. 19 (Address) 1800 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Sept 11th 1923
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 Monument St

N. B.—WRITE PLAINLY. WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING.

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79003

CERTIFICATE OF DEATH.

113 D79003

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 3607 Ash ST.: 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence F. Chaney

(a) RESIDENCE. NO. 3607 Ash ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21st 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Ernest Chaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Hoskins

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

14 Informant (Address) Mr. Ernest Chaney 3607 Ash St

15 Filed SEP 10 1923 Robert P. Harrison, Registrar

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from June 19th 1923, to Sept 9th 1923, that I last saw h[illegible] alive on Sept 9th 1923, and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:

(a) Broncho-pneumonia

(b) Influenza Streptococcus Hemolyticus

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) C. A. Fullerton, M. D.

(Address) 1727 Union Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairview Burial Ct.	Sept 11th 1923

20 UNDERTAKER William H. Hagen ADDRESS 3624 Ash St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79004

CERTIFICATE OF DEATH.

162 D79004

1-PLACE OF DEATH Johns Hopkins Hospital.

CITY OF BALTIMORE: (No. ..... ST., 14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Stern

(a) RESIDENCE NO. 1105 McCulloh ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 4, 1923

7 AGE: Years ..... Months ..... 2 Days ..... If LESS than 1 day, hrs. or min. .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Johns Hopkins Hospital.

PARENTS

10 NAME OF FATHER: Edw. Stern

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Victoria Days

13 BIRTHPLACE OF MOTHER (city or town) (State or country): D. C.

14 Informant .....

(Address) .....

15 Filed SEP 10 1923, 19 ..... Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 6 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 4, 1923, to Sept 6, 1923.

that I last saw him alive on Sept 6, 1923,

and that death occurred, on the date stated above, at 6:25 p. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [illegible], M. D.

9/10, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	Sept 11 19 23
20 UNDERTAKER	ADDRESS
Con[illegible]	

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

D79005

HEALTH DEPARTMENT—CITY OF BALTIMORE

162 D79005

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1519 Mulliken ST., 6 WARD)

2-FULL NAME Baby Daniels

(a) RESIDENCE NO. 1519 Mulliken ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 1½ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 5, 1923.

7 AGE — Years — Months — Days: 1 — If LESS than 1 day 13 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Daniels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah Tilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Sarah Daniels
(Address) 1519 Mulliken St.

15 Filed . 19 Registrar

SEP 01923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 6 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 5, 1923, to Sept 6, 1923, that I last saw h[illegible] alive on Sept 6, 1923, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:
Congenital Atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E E Duncan, M. D.

9/7, 1923 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: Sept 8 1923

20 UNDERTAKER

ADDRESS

Commissioner of Health

Robert P. Harrison

Asst. Vital Statistics Clerk

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79006

D79006

CERTIFICATE OF DEATH.

113

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2930 Erdman Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Rowland Grauer

(a) RESIDENCE NO. 2930 Erdman ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 28 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 3 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Henry Grauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Elsie M Harcourt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Elsie Grauer

(Address) 2930 Erdman Ave

15 Filed SEP 10 1923, 19 Robert P. Harrison, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1923, to Sept 10, 1923, that I last saw him alive on Sept 9, 1923, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Entero-Colitis - acute -

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) F. J. Kinsey, M. D.

Sept 10, 1923 (Address) 2705 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Jerusalem Cem

DATE OF BURIAL Sept 11 1923

20 UNDERTAKER John Ullrich

ADDRESS 2108 Edison

Spec.—1-10-21—M&T—1500 Bks.

D79007

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79007

CERTIFICATE OF DEATH.

REGISTERED NO. 38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1448 Morton ST., 17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Davis

(a) RESIDENCE NO. 1448 Morton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 7 1923

7 AGE	Years	Months	Days	If LESS than 1 day, ? hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Joe Davis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Rachael Taylor

13 BIRTHPLACE OF MOTHER (city or town) Cookesville
(State or country) Maryland

14 Informant
(Address)

15 Filed SEP 10 1923, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 7, 1923, to Sept 7, 1923, that I last saw h alive on Sept. 7, 1923, and that death occurred, on the date stated above, at 11 4. m.

The CAUSE OF DEATH* was as follows:

Intra uterine malnutrition

(duration) yrs. mos ½ ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Susanne R Parsons M. D.

9-8-1923 (Address) 1702 Westwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL Sept 8 1923

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should note CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79008

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79008

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 804 S. Port St. ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Tribull

(a) RESIDENCE. No. 804 S. Port St. ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Anna Tribull

6 DATE OF BIRTH (month, day, and year) Aug. 14 - 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	—	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Paul Tribull

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Marsh (daughter)

(Address) 804 S. Port St.

15 Filed SEP 10 1923, 19.....

Robert F. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1922, to Sept 8, 1923, that I last saw him alive on Sept 7, 1923, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. L Burke, M. D.

, 19 (Address) 3042 Henderson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem.	Sept. 11 1923

20 UNDERTAKER Lilly & Gerber

ADDRESS 403 S Wood Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79009

CERTIFICATE OF DEATH.

129 ✓ D79009

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 736 W. Hamburg ST.: WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Van Der Linden

(a) RESIDENCE. No. 736 W. Hamburg ST. WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 10 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert P. Van Der Linden

6 DATE OF BIRTH (month, day, and year) Oct 20th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	10	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Albert P. Van Der Linden
(Address) 736 W. Hamburg st

15 Filed SEP 10 1923 19.. Robert P. Harris
Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1923

17 I HEREBY CERTIFY, That I attended deceased from July 1 1923 to Sept 8 1923.
that I last saw her alive on Sept 8 1923.
and that death occurred, on the date stated above, at 3 P m.
The CAUSE OF DEATH* was as follows:

Cedema of Lungs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Walter A Cof, M. D.

Sept 10 1923 (Address) 541 Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Sept 12 1923
20 UNDERTAKER	ADDRESS 1034
E Schloman & Son	Baltimore

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

16477
D79010

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 57 D79010

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. " " " ST., 9 WARD)

2-FULL NAME Bessie Riffle

(a) RESIDENCE NO. 200 Reeves Ave. ST., Fairmont, W. Va. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Samuel Riffle (husb)

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 36 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): W. Va.

PARENTS

10 NAME OF FATHER: Abraham Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Alice Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va.

14 Informant (Address): Records JOHNS HOPKINS HOSPITAL

15 Filed SEP 10 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 8 1923

17

I HEREBY CERTIFY, That I attended deceased from June 29, 1923, to Sept 8, 1923, that I last saw her alive on Sept 8, 1923, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

Lung Abscess (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/25/23

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) T. R. Hammond, M. D.

9/10, 19 23 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fellowship W. Va.

DATE OF BURIAL: Sept 10, 23

20 UNDERTAKER: Joseph Abrams

ADDRESS: 221 Bway

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79011

129 D79011

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., 24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James A. O'Donnell

(a) RESIDENCE NO. 405 Warren Ave ST., 24 WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) June 7 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician 054

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Wm. O'Donnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary A. O'Donnell

(Address) 405 Warren Ave

15 Filed SEP 11 1923, 19... ROBERT N. KRAUTER, Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 7 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 1, 1923, to Sept 7, 1923, that I last saw him alive on Sept 7, 1923, and that death occurred, on the date stated above, at 8:35 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) myocarditis, nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. examination

(Signed) James P. Malloy M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Stone. DATE OF BURIAL 9/11 1923

20 UNDERTAKER John F. Hughes Sons ADDRESS 1318 Eutaw St

D79012

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 D79012

CERTIFICATE OF DEATH.

Registered No. C.....

1-PLACE OF DEATH

City of BALTIMORE: (No. 2229 E. Madison St. 7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Louise M. Meyer.

(Residence in Baltimore: No. 2229 E. Madison St.; yrs. ..... mos. ..... ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, ~~Married,~~ Widowed, ~~or Divorced,~~ (Write the word.) Widow

6-DATE OF BIRTH. March 9, 1854
(Month) (Day) (Year)

7-AGE. 69 yrs. 6 mos. ..... ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. at home
(b) General nature of industry, business, or establishment in which employed (or employer). do

9-BIRTHPLACE, (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Not known

11-BIRTHPLACE OF FATHER, (State or Country). " "

12-MAIDEN NAME OF MOTHER, " "

13-BIRTHPLACE OF MOTHER, (State or Country). " "

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. W. Meyer

(Address) 2329 E. Madison

15- Filed SEP 11 1923, 192.. ROBERT R. KRAUTER, Burial Permit Clerk. Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH. Sept. 9, 1923
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(Duration) ..... Yrs. ..... Mos. ..... ds.

CONTRIBUTORY (Secondary) Broken Compensation

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Geo. Clinton Ladd M. D.
(Coroner)

Sept 10 1923 (Address) 1436 N. Eutaw

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19-PLACE OF BURIAL OR REMOVAL. Baltimore DATE OF BURIAL. Sept. 12 1923

20-UNDERTAKER. Sickler & Sickler ADDRESS 1734 Eager

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Spec.—8-2-14—M. & T.—2000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79013

CERTIFICATE OF DEATH.

38 D79013

REGISTERED No. C.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1728 E Madison ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo Samuel Taylor

(Residence in Baltimore: No. 1728 E. Madison St St.; yrs. 6/12 mos. ds.)

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE, C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) Single

6-DATE OF BIRTH, Dec 25, 1880
(Month) (Day) (Year)

7-AGE, 43 yrs. — mos. — ds.

If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Teamster
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Md.

PARENTS.

10-NAME OF FATHER, unknown

11-BIRTHPLACE OF FATHER (State or Country), unknown

12-MAIDEN NAME OF MOTHER unknown

13-BIRTHPLACE OF MOTHER (State or Country), unknown

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Elizabeth Askins

(Address) 1728 E Madison St

15-

Filed SEP 11 1923, 191.... ROBERT R. KRAUTER, Burial Permit Clerk.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept 8, 1923.
(Month) (Day) (Year)

17-I HEREBY CERTIFY, That I attended deceased from Sept 1 1923, to Sept 8 1923, that I saw him alive on Sept 1 1923, and that death occurred, on the date stated above, at 9 10 p. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

uncertain (Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Lues

uncertain (Duration) ....yrs. ....mos. ....ds.

(Signed) [illegible] M. D.

9/10, 1923 (Address) 1429 E Monument

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Asbury Cemetery — DATE OF BURIAL, Sept 12, 1923

20-UNDERTAKER Jos. Rochester — ADDRESS 1413 E Jefferson St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

D79014

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D79014

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 752 W. Fayett St ST., 4 WARD)

2-FULL NAME Virginia J. Russell

(a) RESIDENCE NO. 752 W. Fayett St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Conrad F. Russell

6 DATE OF BIRTH (month, day, and year): May 26, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: William H. Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Annie M. Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Conrad F. Russell

(Address) 752 W. Fayett St

15 Filed SEPT 11 1923 ROBERT B. KRAUTER Registrar

Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9th 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 1st 1923. to Sept 9 1923.

that I last saw her alive on Sept 9 1923.

and that death occurred, on the date stated above, at 1.30 Am.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilitation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Glassman M. D.

Sept 10 1923 (Address) 2687 Ureph

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: Sept 11 1923.

20 UNDERTAKER: Harry N. Witzke — ADDRESS: 1531 W. Lombard

Reg. No. .....

Date .....

Patient's Name .....

DR. HARRY GLASSMAN,

Office, 742 W. Fayette St.

Phone, St Paul 5087

Office Hours
9 to 10 A. M.
1 to 2 P. M.
7 to 9 P. M.

Address .....

B

Dr. A. Jones Hewett Summit

Dear Sir.

The age stated in Death Certificate
of Mrs Eugenia S. Russel is incorrect.
It should be 55 years instead of 61.
Kindly make the necessary change.

Sept 14 / 23 H Glassman

LOUIS G. EBERHARDT
PRESCRIPTION PHARMACIST
631 W. LEXINGTON ST., Cor Arch
BALTIMORE, MD.

Full Name .....

M D

Spec.- 1-10-21 M&T 1500 Blks.

D79015

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 D79015

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Balto., Md.

CITY OF BALTIMORE: (No. 3055-W. North Ave ST., 15 WARD)

2-FULL NAME William R. Williams

(a) RESIDENCE NO. 3055-W-North Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice K Williams

6 DATE OF BIRTH (month, day, and year) June 5 - 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	51	2	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Barber
(b) General nature of Industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delaware -

PARENTS
10 NAME OF FATHER Elisha Williams
11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Lee H Wright
(Address) 2917 Forrest Park Ave

15 Filed SEP 11 1923, 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug. 30, 1923, to Sept. 9, 1923, that I last saw him alive on Sept. 7, 1923; and that death occurred, on the date stated above, at 12 00 m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mon ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) S. W. Kinney, M. D.

, 19 (Address) 1812 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL Sept 11 1923

20 UNDERTAKER W J Richardson — ADDRESS North Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

D79016

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 D79016

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 708 E. Balto. ST.: 5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Becker

(a) RESIDENCE. No. 708 E. Balto. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., If of foreign birth? 39 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: late Wm. Becker

6 DATE OF BIRTH (month, day, and year): 1850

7 AGE: Years 73 Months 2 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wm. Pensel
(Address) 2030 E. 31st st.

15 Filed SEP 11 1923, 19 ROBERT R. KRAUTER Registrar
Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 9. 9. 1923

17 I HEREBY CERTIFY, That I attended deceased from August 27 1923, to Sept. 9 1923.
that I last saw her alive on Sept. 9 1923
and that death occurred, on the date stated above, at 9 10 P. m.
The CAUSE OF DEATH* was as follows:

Carbuncle (Neck) 13 ds.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Diabetes Mellitus 2
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 8/29/23,

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hilles K. A. Meyer M. D.

9/11, 1923 (Address) 1031 N. Caroline st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL: 9/12/23 19

20 UNDERTAKER: Wendell Dippel ADDRESS: 378 Lem

Spec– 12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79017

CERTIFICATE OF DEATH.

129 D79017

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1136 W. Pratt St. St., 18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Hurley

(a) Residence No. 1136 W. Pratt St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Hurley

6-DATE OF BIRTH (month, day and year) July 18, 1867

7-AGE, 55 yrs. 8 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Ireland

PARENTS.

10-NAME OF FATHER, John Hurley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Ireland

12-MAIDEN NAME OF MOTHER, Mary Driscoll

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Ireland

14- (Informant) Mrs. Hurley.

(Address) 1136 W. Pratt St.

15- Filed SEP 11 1923 ROBERT R. KRAUTER Registrar.

Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept. 10. '23

17- I HEREBY CERTIFY, That I attended deceased from Jan. 2, 1923 to Sept. 10, 1923

that I last saw h 1m alive on 1923

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Chronic Nephritis

(Duration) 2 yrs. mos. ds

CONTRIBUTORY (Secondary) Uremia

(Duration) yrs. 7 mos. ds

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. J. Coolahan, M. D

9/10, 1923 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. | DATE OF BURIAL Sept 12 1923

20-UNDERTAKER John J. Toledo | ADDRESS 1200 W Fondaul

Spec.—1-10-21—M&T—1500 Blks.

165923 D79018

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 31 ✓ D79018

REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. " " ST., H WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Jenkins.

(a) RESIDENCE NO. 1106 Mc Culloh St. City ST. WARD 16

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. 6 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a (If married, widowed, or divorced HUSBAND of ~~or WIFE~~ of John Vance, (Friend)

6 DATE OF BIRTH (month, day, and year) Jan. 20, 1901.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) ——
(State or country) S. C.

PARENTS

10 NAME OF FATHER Pink. ——

11 BIRTHPLACE OF FATHER (city or town) ——
(State or country) S. C.

12 MAIDEN NAME OF MOTHER Eugenia Epps

13 BIRTHPLACE OF MOTHER (city or town) ——
(State or country) S. C.

14 Informant JOHNS HOPKINS HOSPITAL Records
(Address)

15 Filed SEP 11 1923, 19 ROBERT R. KRAUTER, Burial Permit Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 8 1923

17

I HEREBY CERTIFY, That I attended deceased from Aug 24, 1923, to Sept 8, 1923, that I last saw him alive on Sept 8, 1923, and that death occurred, on the date stated above, at 3:40 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 0 yrs. 3 mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ——

Did an operation precede death? No Date of ——

Was there an autopsy? Yes

What test confirmed diagnosis? Sputum Pos. Tubercle bacilli

(Signed) R R. Hannon, M. D.

9/9, 1923 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenwood S. C.

DATE OF BURIAL 9-11-23

20 UNDERTAKER Daniel Easton

ADDRESS 976 Penna ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

A K S • S E T

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state
TION is very important. See instructions on back of certificates.

1-PLACE O

CITY OF BALTI

2-FULL NAM

(a) RESIDENCE
(Usual plac
Length of residence in city or t

PERSONAL AN

3 SEX: Male

4 COLOR: Colo

5a If married, widowed, or div
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day,

7 AGE: Years 47 | Mo

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balt
(State or country)

PARENTS

10 NAME OF FATHER Mos

11 BIRTHPLACE OF FATHER (city or to
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14
Informant Municipal Hospital
(Address)

15
Filed . 19

Spec.—1-10-21—M&T—1500 Bks.

D79020

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 D79020

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1829 W. Fairmount St., 20 WARD)

2-FULL NAME Henry F Hesselbacher

(a) RESIDENCE NO. 1829 W Fairmount St., 20 WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
male	white	married

5a If married, widowed, or divorced
~~HUSBAND~~ of
~~WIFE~~ of Lula C. Hesselbacher

6 DATE OF BIRTH (month, day, and year) Sept 4, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer Hooper Mills

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Christian Hesselbacher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lula Hesselbacher
(Address) 1829 W Fairmount Ave

15 Filed SEP 11 1923 19 ROBERT R. KRAUS Registrar
Burial Permit Issued

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1923

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1922 to Sept 10, 1923.
that I last saw ~~him~~ alive on Sept 7, 1923.
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Coronary Heart Disease

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

9/11, 1923 (Address) 930 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Sept 17, 1923

20 UNDERTAKER William Cook

ADDRESS 501 E Fayette Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful in giving information should be stated EXACTLY. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

D79021

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1/22 - 001 D79021

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. ST., 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gus Kirsch

(a) RESIDENCE NO. Aa. county Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sarah Kirsch

6 DATE OF BIRTH (month, day, and year) Sept-24-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer & Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hessen Kassel

14 Informant Hospital Records (Address) [illegible] 03 E. 5th St.

15 Filed SEP 11 1923 19 ROBERT R. KRAUTER Registrar Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 - 1923

17 I HEREBY CERTIFY, That I attended deceased from Aug 25, 1923, to Sept 10, 1923, that I last saw h[illegible] alive on Sept 10, 1923, and that death occurred, on the date stated above, at 5:30 p.m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

Intestinal Stasis - Tympanites

(duration) yrs unknown ds.

CONTRIBUTORY (Secondary) Biliary Jaundice (duration) yrs mos. 16 ds.

18 Where was disease contracted if not at place of death? Aa. County Md.

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

, 19 (Address) Univ. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Sept 12 1923

DATE OF BURIAL

20 UNDERTAKER Wm Cook 502 E Fort Ave

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPA- CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 D79022

D79022

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bay View Hospital

CITY OF BALTIMORE: (No.) ..... ST., 10 WARD)

2-FULL NAME Frederick Seyfarth

(a) RESIDENCE No. 1029 Greenmount Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~Eight~~ 11 Years yrs. mos. ds. How long in U. S., if of foreign birth? 11 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
50.				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer Belvedere Hotel

9 BIRTHPLACE (city or town) Germany

(State or country) Switzerland

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) Do

(State or country)

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) Do

(State or country)

14 Informant Bay View Hospital

(Address) Baltimore Md.

15 Filed ..... , 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 9. 1923

17 I HEREBY CERTIFY, That I attended deceased from June 10. 1923 to Sept 9. 1923

that I last saw h alive on Sept 8 1923

and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis (of the Insane)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis (Confirmed)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes What test confirmed diagnosis? Clinical + Pathological

(Signed) N. Goldsmith M. D.

. 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Franklin Sq.	11 1923
20 UNDERTAKER Wm Cook	ADDRESS 502 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—PHYSICIANS should take this information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

ROBERT N. KRAUTER
REGISTRAR OF VITAL STATISTICS
BUREAU OF VITAL STATISTICS

Spec.—1-10-21—M&T—1500 M.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79023

CERTIFICATE OF DEATH.

31 ✓ D79023

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2542 West Lanvale ST. (WARD) 16

2-FULL NAME Catherine A Helmter

(a) RESIDENCE NO. 2542 W. Lanvale ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frederick J. Helmter

6 DATE OF BIRTH (month, day, and year) Nov 7 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John T. Hannigan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Celia Tierney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant (Address) Frederick J. Helmter 2542 W. Lanvale

15 Filed SEP 11 1923 19 ... ROBERT R. KRAUSE Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9 1923

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1923, to Sept 9, 1923.

that I last saw h-- alive on Sept 9 1923

and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Anaemia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pulm. TB (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) G. Williams M. D.

9/10, 1923 (Address) 1302 N. Fremont

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL Sept 12 1923

20 UNDERTAKER W M Cook

ADDRESS 1020 N Eutaw

Burial Permit

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Information on back of certificates. See instructions on back of certificate. TION is very important.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79024

CERTIFICATE OF DEATH.

100-001

D79024

1-PLACE OF DEATH Bay View Hospital W

CITY OF BALTIMORE: (No. ..... ST., WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Brown

(a) RESIDENCE NO. 514 S. Chapel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Mary G. Brown

6 DATE OF BIRTH (month, day, and year) Dec 29 78 78

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) 062

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Brown

11 BIRTHPLACE OF FATHER (city or town) U. S. (State or country)

12 MAIDEN NAME OF MOTHER Mary Coyle

13 BIRTHPLACE OF MOTHER (city or town) Ireland (State or country)

14 Informant (Address) Bay View Hospital Md.

15 Filed SEP 11 1923, 19 ..... ROBERT R. KRAUTER, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9, 1923

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1922 to Sept 9, 1923

that I last saw h[illegible] alive on Sept 9, 1923

and that death occurred, on the date stated above, at 3:10 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia (Terminal)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Agitated Depression

Myocardial Insufficiency (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) N. Goldwater M. D.

, 19 (Address) Bay View Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Sept 12 1923
20 UNDERTAKER Lilly & Zeiler	ADDRESS 408 S. Wolfe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state EXACTLY. AGE should be carefully supplied. Exact statement of OCCUPATION should be stated EXACTLY. AGE, should be properly classified. Exact statement of OCCUPATION should be stated EXACTLY

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79025

CERTIFICATE OF DEATH.

13 D79025

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2645 Bernard St. W. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Shuler

(a) RESIDENCE. NO. 2645 Bernard St WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 30 1922

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work c

(b) General nature of industry, business, or establishment in which employed (or employer) c

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Charles A Shuler

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Hilda E Baker

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Charles A Shuler
(Address) 2645 Bernard St

15 Filed ..... 19 .....
Registrar

SEP 11 1923 ROBERT R. KRAMER
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1923

17 I HEREBY CERTIFY, That I attended deceased from Sept 8, 1923, to Sept 10, 1923, that I last saw him alive on Sept 10, 1923, and that death occurred, on the date stated above, at 1130 A m.

The CAUSE OF DEATH* was as follows:

acute intestinal intoxication

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M Arthur Darby, M. D.

, 19 (Address) 2821 Dulaney Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mays Hampden	Sep 11 1923

20 UNDERTAKER CHENOWETH & SON, ADDRESS 3617 CHESTNUT AVE.

N. B.—WRITE PLAINLY, WITH UNFADING INK. PHYSICIAN'S NAME should be stated EXACTLY. PHYSICIAN'S ADDRESS should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIAN'S ADDRESS should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION should be carefully supplied. AGE should be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79026 Body sent to morgue D.U.K. unclaimed. D79026

CERTIFICATE OF DEATH.

REGISTERED No. C

(PLACE OF DEATH

CITY OF BALTIMORE (No. 1254 N. Calhoun St. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bettie Adams

(Residence in Baltimore: No. 1254 N. Calhoun St. 15 St.; yrs., mos. ds.)

WRITE PLAINLY. N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be very careful in stating CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, female

4-COLOR OR RACE, colored

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (*Write* the word.) married

6-DATE OF BIRTH, about (Month) (Day) 186 (Year)

7-AGE, about 55 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 610

9-BIRTHPLACE, (State or Country), N. Carolina

PATIENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (State or Country),

12-MAIDEN NAME OF MOTHER

13-BIRTHPLACE OF MOTHER (State or Country),

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Northwestern Dist. Police

(Address) Penna. Ave.

15-

Filed....., 191.....

Registrar.

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Sept. 5, 1925
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) jury find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Interstitial Nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(Duration) yrs. mos. ds.

(Signed) T. J. Kennedy M. D.
(Coroner.)

Sept. 8, 1925 (Address) 28 E. Fayette St.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL,

DATE OF BURIAL, Sept. 8, 1925

20-UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND
Robert P. Harrison,
Medical Historical Library

0702

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79027

CERTIFICATE OF DEATH.

31 D79027

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Municipal Hospital. ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Baker

(a) RESIDENCE NO. 756 Vine St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Emma Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Municipal Hospital Records. (Address)

15 Filed ..... 19 ..... Registrar

SEP 11 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept. 8, 19 23

17

I HEREBY CERTIFY, That I attended deceased from July 9, 19 23, to Sept 8, 19 23, that I last saw him alive on September 8, 19 23, and that death occurred, on the date stated above, at 10:00 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Pott's Disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Anthony Buchanan, M. D.

9-10 19 23 (Address) Municipal Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND.

Robert P. Harrison, Commissioner Health.

By Wm. F. Woodall

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79028

CERTIFICATE OF DEATH.

90 D79028

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 Roland Ave. ST., 27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella J. Callahan

(a) RESIDENCE No. 402 Roland Ave. ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 1 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) July 29, 1854

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
69	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Timothy T. Callahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaretta Godwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Miss Margaret M. Callahan
(Address) 402 Roland Ave.

15 Filed SEPT 11 1923, 19 ..... Robert P. Harrison, Registrar
Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 10 1923

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1923, to Sept 10, 1923.

that I last saw h alive on " " , 19 " .

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Henry T. Reedy M. D.

(Address) 1 Upland Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	9/12/23 19

20 UNDERTAKER	ADDRESS
Henry W. Mears & Son	805 Calvert St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should be careful to see that information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should be careful to see that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-2:—E.B.R.S.—400 Bks.

D79029 ✓ D79029

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

Registered No.....

1-PLACE OF DEATH

City of BALTIMORE: (No. Sutton District of this Post 10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Oliver

(a) Residence No. Preston Valley Ho St., Ward.....

(Usual place of abode) (If non resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-~~Single~~, Married, ~~Widowed, or Divorced~~ (Write the word.)

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel Gist.

6-DATE OF BIRTH (month, day and year) Nov. 13, 1855

7-AGE. 67 yrs. 10 mos. 28 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md.

PARENTS.

10-NAME OF FATHER, John Oliver

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto. Md.

12-MAIDEN NAME OF MOTHER, Susan Elsorode

13-BIRTHPLACE OF MOTHER (city or town) (State or Country).

14- (Informant) Sister Florence

(Address) Preston & Valley

15- Filed ..... 192.....

Robert P. Harrison, Registrar.

SEP 11 1923 Burial Permit Clerk.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) Sept 11/23

17- I HEREBY CERTIFY, That I attended deceased from ..... 19.... to Sept 19 23 that I last saw h.... alive on Sept 7 19 23 and that death occurred, on the date stated above, at 11 45 m. The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

Sept 11, 1923 (Signed) F. A. Warner M. D. (Address) 1133 Valley St

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Green Mount Cem. DATE OF BURIAL. Sept. 13, 1923

20-UNDERTAKER. Chas S. Black ADDRESS 742 W North ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK. All items should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S DIAGNOSIS should be in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

D79030

CERTIFICATE OF DEATH.

100-001 ✓ D79030

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 108 N Caroly ST. 18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda Johnson

(a) RESIDENCE NO. 108 N Caroly ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Johnson

6 DATE OF BIRTH (month, day, and year) — — 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) Laundress

(c) Name of employer at Home

9 BIRTHPLACE (city or town) (State or country) A A Co Md

PARENTS

10 NAME OF FATHER Henry Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) A A Co Md

14 Informant Chas Moore

(Address) 108 N Caroly St

15 Filed SEP 12 1923, 19 Robert P. Harrison, Registrar

Burial Permit Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 9th 1923

17

I HEREBY CERTIFY, That I attended deceased from Sept 6th, 1923, to Sept 9th, 1923, that I last saw h[illegible] alive on Sept 9th, 1923, and that death occurred, on the date stated above, at 6 20 P m.

The CAUSE OF DEATH* was as follows:

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) — yrs — mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edward E. Mackenzie, M. D.

9/10, 1923 (Address) 1339 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL Sept. 12, 1923

20 UNDERTAKER Mrs G W H Hooper — ADDRESS 406 W. Conway St

N. B.—WRITE PLAINLY, WITH UNFADING INK—PENCIL NOT ACCEPTABLE. Exact statement of OCCUPATION should be stated EXACTLY. PHYSICIAN'S mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.